the Canadian Nurse

VOLUME 57 • NUMBER 7
MONTREAL
JULY 1961

HIGHLIGHTS

KERR — Congress Commentary

STEWART, DANTO & MADDIN — Sun Worshippers, Beware!

JOURARD — Roles That Sicken and Transactions That Heal

CROW — Bleeding Duodenal Ulcer

BREAULT — Phlebitis

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THE CANADIAN NURSES' ASSOCIATION

CLINICAL REPORT

SUBJECT: On a Specific Benefit of Meat in the Infant Diet

"These results suggest that the addition of meat to the diet supplied a pool of iron for subsequent hemoglobin synthesis and that an increase of iron stores had occurred in the infants given this supplement. The expansion of red cell volume and circulating hemoglobin mass in the meat-fed group was greater than in the controls."

Excerpt from "Meat in the Diet of Premature Infants," Sisson & Whalen, A.M.A. Journal of Diseases of Children, Vol. 95, Pg. 635. 1958. Available on request.

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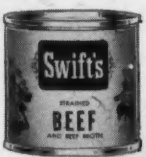

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JULY, 1961

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THE CANADIAN NURSE

VOLUME 57 **NUMBER 7**

JULY 1961

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Between Ourselves

As the lead article, our formal report of the recent Congress of the ICN appears in this issue. Here, in this more informal column, is a more appropriate spot to touch upon some of the very unofficial aspects of this year's meeting which may be of interest to many of you.

Perhaps the best place to start will be with the exhibit prepared by National Office, CNA, one section of which was shared by the *Journal*. Considerable interest was evoked by the slogan we used: "The Canadian Nurse Spans the World." On the map of the world, lines connected Montreal to the 103 countries to which our *Journal* is distributed every month. The change of color appearing on each month's issue added a pleasant note to the display.

Arrangements had been made with our government to provide the beautifully illustrated booklet "An invitation to Canada." If all of the nurses who secured copies accept that invitation there will be a big jump in the number of nurses coming from abroad, particularly from Australia, for every one of the hundreds of copies that were put on display was snapped up.

A very welcome support to the nurses who will be expected to report to their organizations back home were the daily news sheets that summarized the highlights of the sessions and added choice bits of gossip heard in the corridors. A special tribute must be paid to Miss MARJORIE CONNOR, secretary of the Royal Victoria College of Nursing, Melbourne, who was the editor of these daily bulletins. Miss Connor was also the author of the Welcome song used during the opening session.

Of course there was much confusion among people unaccustomed to pounds, shillings and pence. The Bank of New South Wales not only maintained a very friendly staff at the Congress hall where we could exchange our money but they also arranged for tickets for all the local sightseeing tours. One Canadian nurse started for home carrying *seven pounds* of the large Australian pennies, each with a kangaroo imprinted on it. They were to be souvenirs for each member of the group who had sponsored her trip. She had to carry them herself because the added weight in the luggage would have put it past the permitted 44 pounds!

The cooler weather was probably the reason why the gaily colored costumes of many races were so much less in evidence than they were in Rome in 1957. Probably the most colorful group were the nurses from Ghana, each of whom was resplendent in brilliant yellows, greens, reds and blues. A male nurse from Nigeria was also much photographed in his flowing robes.

Even as we congratulated the new officers on their election, we Canadians felt sincere regret that neither of our members who had been nominated were elected. The Canadian Nurses' Association is one of the largest of the member countries and is anxious always to give each of us significant representation in world-wide nursing affairs.

* * *

Dr. RAE CHITTICK has drawn our attention to a sentence that was omitted from her article in the May issue. On page 441, twelve lines from the bottom of the right hand column appears the sentence — "A hospital of 400 beds employed 69 professional nurses and 54 auxiliary nurses for bedside nursing." This should have been followed by "Another hospital of the same size employed five professional and two auxiliary nurses."

Obviously, the greater part of the load of bedside care in the latter institution was carried by the students.

Pharmaceuticals

and other products

KA-PEN (PFIZER)

Indications—The treatment of infections requiring rapid, high blood levels of penicillin.

Description—Each scored tablet contains 500,000 I.U. Penicillin G Potassium and buffering agents.

Administration—Orally, 3-4 times daily, depending on the age of the patient and the severity of the infection.

MAYSCO STERILE-TREAD (CHEMETRON)

Uses—To minimize the transporting of bacteria, by disinfecting shoes and wheels of rolling equipment on entrance to operating suites, nurseries and delivery rooms.

Description—Consists of a pan, which contains a thin plastic sponge material, and covered with canvas. The sponge is saturated with a disinfectant solution. It has sufficient resilience to permit an imprint which forces the disinfectant to penetrate the canvas and contact the bottom and sides of shoe soles and wheels of equipment. Units are custom made but generally are 12 feet long and nearly as wide as the corridors or entries in which they are installed.

NURSING HOME RECORD FORMS (PHYSICIANS' RECORD COMPANY)

Description—An illustrated circular which describes record forms covering all aspects of the patients medical record — admission agreement, summary sheet, index card, authorization and release, history and physical examination, doctor's orders and notes, patients care record, nursing notes, etc. Write for "Circular NH," Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois.

PANWARFIN (ABBOTT)

Indications—For the treatment and prophylaxis of intravascular thrombosis and embolism.

Description—Each tablet contains: warfarin sodium [3-(α-Acetonyl-benzyl)-4-hydroxycoumarin sodium] 5 mg., 10 mg. or 25 mg.

Administration—Orally in individualized doses.

Precaution—The patient must be constantly supervised and the dosage controlled by daily prothrombin determinations.

PLEGINE (AYERST)

Indications—In the management of obesity wherever excessive appetite is responsible.

Description—Each tablet contains 35 mg. of phendimetrazine bitartrate.

Administration—One tablet b.i.d. or t.i.d., one hour before meals. In some cases ½ tablet may suffice; in others 2 tablets may be required.

RONCOVITE (HOECHST)

Indications—Hematinic therapy in iron-deficiency anemia and secondary anemia.

Description—Each tablet contains 15 mg. cobalt chloride and 0.2 Gm. exsiccated ferrous sulfate.

Administration—Adults: 1 tablet t.i.d. and h.s.

SHANDON LACE PLACE MATS (WOOD)

Use—To enhance the appearance of patients' meal trays.

Description—Paper lace mats, embossed with scalloped edges. Size 10" x 14¼".

STELABID (SMITH KLINE & FRENCH)

Indications—For the treatment of gastrointestinal disorders.

Description—A combination of isopropamide, an antispasmodic and antisecretory agent and trifluoperazine an anti-anxiety and anti-emetic agent.

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TSI TAPE (PROFESSIONAL TAPE CO.)

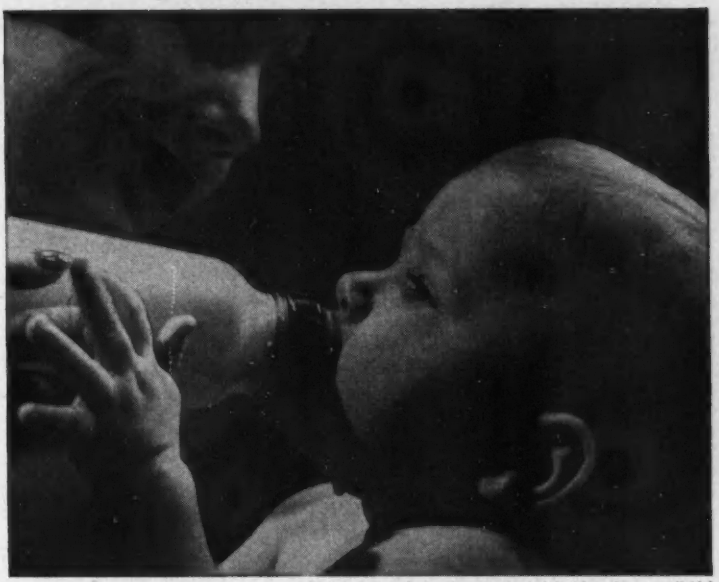
Description—A pressure-sensitive paper tape to which has been applied a chemical which responds to the standard autoclaving cycle of 250°F. for a period of 15 minutes. It can be used on any package, wrapper or container, the word "Sterile" appearing on the tape in black letters at the required sterilizing values.

WILSON TRU-TOUCH GLOVE (BECTON, DICKINSON)

Uses—For any type of digital examination.

Description—Made from a polyvinyl formulation, the glove offers a high degree of sensitivity, and has no seams. Cost is low enough for the glove to be validly disposable.

The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.



The most convenient and most accurate infant formula now available!

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with added Vitamins C and D

Next time you prescribe an infant feeding, consider the advantages of Farmer's Wife Prepared Formula—ready for baby's bottle with the one simple addition of boiled water. This newest infant formula from Farmer's Wife, is the only product of its type with added Vitamin C, essential in the prevention of scurvy. Its Vitamin D content is also important to every baby's healthy growth. Two formula strengths are available, based on whole or partly skimmed milk. In both, the baby sugar is already combined with the milk, ensuring accuracy of preparation. Farmer's Wife Prepared Formula has been tested thoroughly and successfully by pediatricians and hospitals, and by a large panel of mothers. It has proved to be exceedingly well balanced, to suit the majority of normal children. Consider safe, accurate, easy Prepared Formula when prescribing feedings for your youngest patients.

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Prepared Formula Red Band • **Prepared Formula Blue Band** • **Whole milk** • **Partly skimmed milk** • **Skimmed milk**
(Whole Milk) (Partly Skimmed Milk)

Random Comments

Dear Editor:

Your idea of the little preview of coming articles will be appreciated by many "nosey" people like myself who can't wait to see what is coming next. It's something like wanting to know what's inside the parcel before Xmas Day arrives.

Listing the five main features on the front cover is another good idea. It pleases "lazy" people like myself who hate to have to look inside the cover to find a certain article. By the way, "Erythroblastosis" by Dr. Holman was wonderful!

The March issue on ophthalmological conditions was one of the most valuable issues, I feel, that we — I mean you — have put out for a long time. It is really so much more handy to have related material all in one edition, rather than having to search through half a dozen different issues for it.

I was wondering about the proposed multi-language chart that Miss Kerr mentioned in the April "Between Ourselves" for use in hospitals. You won't forget the nurse in the admitting department and clinic or the public health nurse, will you? Such phrases as: "In what country were you born? How long have you been in Canada? What is your age? What is your present address? Have you ever been treated for tuberculosis?" would all be invaluable to the P.H. nurse. I wasn't sure whether the plans were for strictly medical phrases and questions or whether this general type would be included as well. Incidentally, if such a list is prepared, *please* don't omit Greek!

ELDA Y. DUNHAM, Ontario

Dear Editor:

I should like very much to request a copy of the March, 1961, issue of your publication. I have only recently been introduced to the *Journal* and am finding it of tremendous value. Because I teach nursing conditions of the eye, I found the March issue to be of special interest.

I intend to become a regular subscriber.

JUDITH K. BURNS,
Cleveland, Ohio

Dear Editor:

I am somewhat confused by an advertisement on page 173 of the February issue of *The Canadian Nurse* wherein the readers, presumably nurses (*nurses*, mind you) are

urged to add a few dollars to their income by promoting the sale of a certain brand of cigarettes.

Aren't we the fun-spoilers who are always preaching about the effect of nicotine on the heart muscle and of smoke particles on the lining of the lungs? Are we no longer waiting with bated breath to find out if tobacco has any connection with lung cancer? Are we now to reverse our exhortations and our hard-won positions in favor of our pocketbooks? Fie! For shame!

EUNICE FLOYD, New Brunswick

Dear Editor:

I would like to draw your attention to the article "Retinal Detachment" which appeared in the March issue. The following sentence was in the sub-heading "Surgery is the main form of treatment" and in the last paragraph under the heading Diagnosis and Treatment it states "Routine treatment will be bed rest flat on the back with both eyes covered for a variable length of time. The retina often resumes its position which lessens the need for surgery."

I feel that these statements are very misleading leaving the nurse with the feeling that detached retinas will become attached by themselves, alleviating the necessity for surgery.

Placing the patient on bed rest, with both eyes padded, will give the retina a chance to fall back into place, but unless surgery, including diathermy to produce adhesions has been performed, there is nothing to keep the retina in place once the patient resumes normal activity.

After having spent four and a half years on the Eye, Ear, Nose and Throat ward, it has been my observation that surgery is the only treatment for detached retina due to retinal tears.

PAT SCOTT, Manitoba

¶*The statement you quote re: "lessens the need for surgery" could have been further qualified and perhaps would have prevented your being misled. It might have read "lessens the need for surgery in a limited number of patients." With the successful use of photocoagulation (described on page 244) preceded by the routine of bed rest, the need for surgery is eliminated in selected patients.* Ed.

Dear Editor:

It is quite time that I wrote to thank you for *The Canadian Nurse* which comes faithfully each month. It is very interesting and I pass it on to other retired nurses.

I have been ill for about a year and a half but am better now. I am a graduate of the Calgary General Hospital, 1901, and still take an interest in nursing matters, although I can no longer go around much. I am 86½ years old, my husband is 81½. We are not well but manage to keep going.

Thank you for your kindness and best wishes to you all.

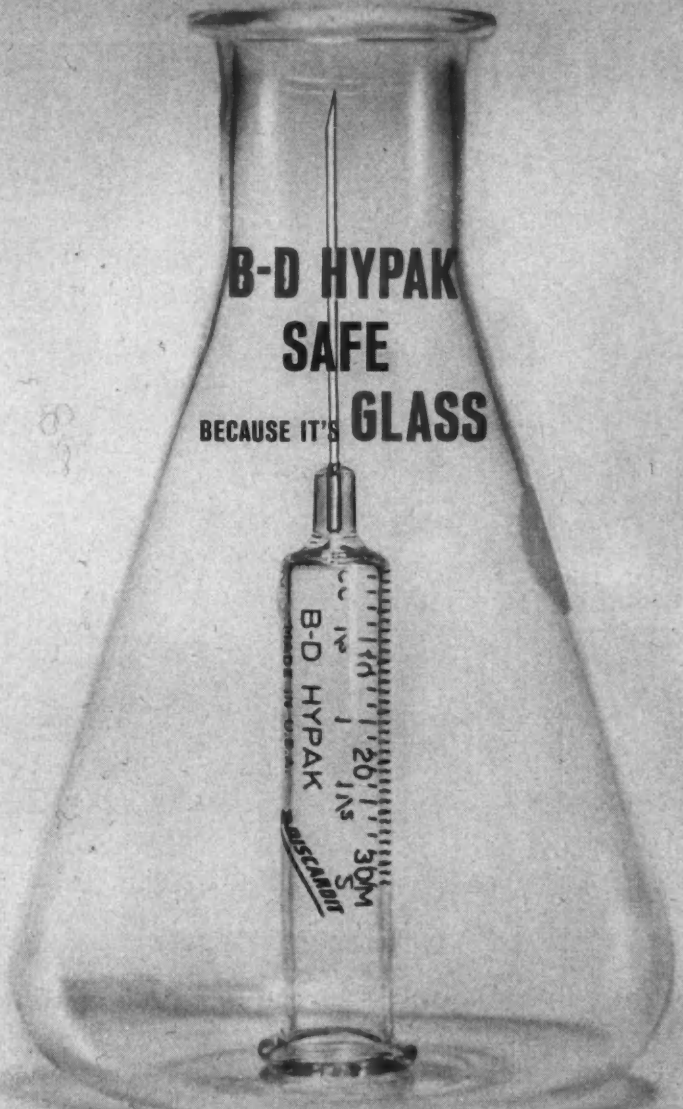
WINNIFRED (COPE) LAMARQUE, B.C.

Dear Editor:

For the benefit of those nurses coming over from 'the old country' and to help Canadian nurses working in England I've compiled a few translations, having had the honor of working in both countries.

Canadian	*English*
Hi	Good morning
Director of nursing	Matron
Head nurse	Ward sister
Asst. head nurse	Staff nurse
Clinical supervisor	Sister tutor
Appendectomy	Appendicectomy
Gastric analysis	Fractional test meal
Levine tube	Ryles tube
Diet	Elevenses
Cookies	Biscuits
Candies	Sweets
Face cloth	Face flannel
Bathroom	Toilet or W.C.
Johnny shirt	Open night gown
Gastric lavage	Stomach wash out
Garbage can	Dust bin
Elevator	Lift
Bobby pins	Hair slides
Surgeon	Mister
Physician	Doctor
Bye	Good night

IRA SEN, Quebec



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Why not suggest "Tampax" to the teenage patient? Its matter-of-fact simplicity, safety and security are outstanding features – sure to be welcome now and in the years ahead.

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 57 NUMBER 7

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CONGRESS COMMENTARY

THE 12TH QUADRENNIAL CONGRESS of the International Council of Nurses drew to a successful conclusion in Melbourne, Australia on Saturday, April 22, after six busy days. Some 2400 nurses from more than forty countries had attended some or all of the sessions; had strolled through the large hall where many national associations had displayed interesting exhibits; had jammed the Royale Ballroom section of Exhibition Hall for noonday lunch and for the two special evening affairs.

Miss AGNES OHLSON, the president, wearing the impressive chain of office that had been presented to the ICN at Rome in 1957 by the national nursing journals, conducted all five of the business sessions of the Grand Council. Highlights of this business and the decisions made are noted later in this report. Following the voting for the new officers at the final business session, a tumultuous welcome was extended to the new president, Mlle ALICE CLAMAGERAN, the second French member to hold this lofty position.

A highlight of the week was International Night when the ICN bade farewell to Miss DAISY BRIDGES who had functioned so efficiently as its general secretary for the past 13 years. Her successor, Miss HELEN NUSSBAUM, had been appointed as general secretary designate several months before the Congress convened.

As Canadian nurses were well aware, an invitation to hold the 1965 Congress in Toronto had been extended. Invitations had also been re-

(Australian N. & I. Bureau)

Canada's official representatives

ceived from the nursing associations in Great Britain and West Germany. Despite the brilliance and persuasiveness of the personal invitation extended by our president, Miss HELEN CARPENTER, to the Grand Council, the voting favored the appeal from Germany. So, Canadian nurses who are interested in attending the 1965 Congress can start right now to save their money for the trip to Frankfort.

Canadian Representation

The lure of travel to far distant points was admittedly a potent factor in the decision of most of the Canadian nurses to attend the Congress. Every province but Newfoundland was represented, with the largest number — 24 — from Ontario. They ranged in age and experience from the two student nurses from Montreal (the only students from all of Canada!) to Miss LAURA LOGAN, who at a youthful-looking 81 is again actively registered in Nova Scotia after an illustrious career in nursing in the United States. Four Canadian missionary nurses, who attended the Congress as part of the delegation from India, were present at the special breakfast party promoted by our president and the executive director of the CNA, Miss M. P. STIVER.

The majority of our delegation joined the special tour organized by the CNA and spent a happy fortnight sightseeing in Honolulu, Fiji and New Zealand on the way to Australia. Space does not permit any recounting of the countless interesting and amusing incidents of this tour nor of the post-Congress trips of most of the Canadian Group. Almost everyone kept up their daily diaries. Most of us took scores of colored pictures. So, we hope that a great many nurses in all parts of Canada will have an opportunity to share in the experiences encountered by our representatives in the months to come.

Pre-Congress Church Services

The two three-spired cathedrals of Melbourne were jammed to the doors for the special services. At St. Paul's Anglican, Miss Ohlson read the first lesson following which Miss Bridges read the International Code of Nursing Ethics. A beautiful garland of flowers was presented to the Dean of the Cathedral by three Congress participants. It was placed before the Altar in honor of Florence Nightingale.

The tour party on the steps of the Art Gallery in Wellington, N.Z.

Concurrently, solemn pontifical high mass was celebrated at St. Patrick's Cathedral. Preceding the mass, a colorful procession moved from the Bishop's Palace with uniformed student nurses forming a guard of honor.

Opening Ceremonies

Grey skies and chilly weather failed to diminish the enthusiastic greetings as the nurses from all over the world, some attired in the colorful costumes of their homelands, gathered for the noonday official opening. After being welcomed to Melbourne by the Lord Mayor, SIR BERNARD EVANS, and the president of the Royal Australian Nursing Federation, Miss GLADYS SCHOTT, the Congress was declared open by General Sir DALLAS BROOKS, administrator of the Commonwealth of Australia. Sir Dallas remarked that nursing is much more than a profession — it is a calling devoted to care of people. He noted that "T.L.C." is a delightful interlude, particularly for the male patient, in an otherwise drab period of hospitalization.

A highlight of the opening session was the 180-voice choir of Australian student nurses who, accompanied by the band of the Royal Australian Air Force, sang the following "Song of Welcome" to the well known tune of Waltzing Matilda:

The Platform Group at the opening

Welcome to Nurses! Greetings, our Colleagues
Gathered together from near and from wide,
Let our voices and minds bring kindness and unity
Sharing the knowledge and wisdom to guide.

Chorus

From the world of the tropics, the world of the snowdrift,
We meet as a Council, with one thought in mind,
Through faith in our effort may we find achievement,
Peace for the body and soul of mankind.

Exhibition Hall, Melbourne, Australia

The Grand Council

In a report such as this it is impossible to include direct quotations from either the reports of the officers of ICN or from the several standing committees. It is proposed, therefore, to include only some of the highlights and to note the action taken on the recommendations.

In assessing needs for the future, Miss Ohlson emphasized that an ***increase in working income*** was of paramount importance. Following the report of the Finance Committee, the Council voted in favor of increasing the per capita membership fee from 16 pence to 32 pence per annum. This action had been anticipated by the Canadian Nurses' Association at its 1960 biennial convention when the annual fee paid by the provincial nurses' associations for each of their members was raised from $2.00 to $4.00.

Applications for membership in the ICN were received from the national associations of 13 countries. The vote of approval increased the number of member countries from 46 to 59. The new countries included: Burma, British Guiana, Egypt, Formosa, Ghana, Jordan, Kenya, Mexico, Nigeria, Poland, Singapore, Thailand and Venezuela.

It has been suggested that it would be of interest and value to Canadian nurses if we were to publish a complete list of the member countries, together with the year when their application for membership in the ICN was accepted. Watch for this listing in a future issue of our *Journal.*

Applications for admission of National Student Nurses' Associations to the International Student Nurse Unit, were received from the following countries: Australia, Sweden, the United States of America. For information on the reaction of the students present at the Congress to the acceptance of these three applications, turn to the special report prepared by Miss CAROLYN ROBERTS, a student at Royal Victoria Hospital, Montreal.

Thorny problems appeared and heated discussions arose from the presentation of the ***proposed revisions to the constitution and by-laws*** of ICN. The core of the dispute was a proposal to limit the use of the term "professional nurse" to a graduate of a generalized program of training, as is the accepted practice in schools of nursing in Canada. This interpretation would eliminate graduates of specialized nursing schools, such as obstetric, pediatric or psychiatric, where no affiliation with a generalized program was provided. The affirmative vote that finally prevailed emphasized the need

(Australian News and Information Bureau)

The Assembly in Exhibition Hall, Melbourne

for those countries presently supporting specialized schools to review their status during the next four years, with a view to securing the adoption of generalized programs. Mlle M. BIHET, the immediate past president, summed up the discussion with her remark:

> Not all nurses in every country have achieved this standard at the present time. However, nurses who graduate from approved schools of nursing during or after 1965 will be expected to have such preparation in order to qualify for ICN membership.

The ***Education Committee*** stressed the need for the translation of any ICN publications into other languages than English and French. All future publications of this committee will carry a notation authorizing translation into the language of any member country. It was noted that over 15,000 letters written by Florence Nightingale had been located and catalogued. Three volumes of source material on Miss Nightingale and her work will be available to students in nursing and in many other fields in the near future. A recommendation that a third F.N.I.F. Seminar on how research methods could be usefully applied to nursing education received unanimous approval.

Some of the Canadians

As additions to the report of the ***Nursing Ethics Committee,*** an extensive bibliography and course outlines for classes in professional adjustments will provide nursing instructors with valuable assistance. The Grand Council approved the preparation of a booklet on this topic. No changes were made in the present Code of Nursing Ethics but the committee recommended that a thorough study be made with a view to possible revision in 1965. The preparation of a pledge, based on the code, for use in graduation ceremonies, was postponed pending a competition among graduate nurses in member countries, for the most suitable wording.

Since matters relating to ***legal responsibilities for nursing practice*** are essentially national rather than international, further study on this question was referred to the Division on Economic Welfare.

At the Banking Centre

The report of the ***Exchange of Privileges Committee*** contained several recommendations of far-reaching interest to travel-prone nurses. The first provides that an applicant "shall have had at least two years of post-basic experience in her own country prior to employment abroad." Another recommendation clarified the position of nurses who do not meet the conditions for registration in the new country where they wish to work or who are unable, because of language difficulties, to undertake the full responsibility of a registered nurse's position. "These nurses be allowed to undertake nursing duties for a specified time under close supervision, the salary being appropriate for such duties."

A statement of the current objectives of the ICN was presented as the ***ICN Platform*** by the Public Relations Committee.

Look for more complete details on all of these committee reports in *International Nursing Review.*

Before concluding this brief review of the business of the Grand Council, mention should be made of a recommendation made by the American Nurses' Association that ICN Headquarters be moved from London to Geneva. A committee is to be appointed to look into the advantages and

disadvantages of such a move, to report at the Congress in 1965.

The election of officers for the coming quadrennium concluded the business sessions. The complete slate is:

President: Mlle Alice Clamageran (France)
1st Vice President: Miss Agnes Ohlson (U.S.A.)
2nd Vice President: Miss Tehmina K. Adranvala (India)
3rd Vice President: Miss Gladys Schott (Australia)
Hon. Treasurer: Miss M. J. Marriott (Great Britain)

First Plenary Session

In the development of the theme of this Congress, "Wisdom and Guidance through Professional Organization," two masterly addresses set the tone for the papers and discussions that filled the program of the four sections into which the Congress participants were divided on the following day. MARIE JAHODA, Ph. D., a noted member of both the British and the American Psychological Societies chose as her topic "Nursing as a Profession." Miss ALICE GIRARD, immediate past president of the Canadian Nurses' Association, applied herself to a direct interpretation of the theme in her address entitled "The Professional Nursing Association and You." Both of these papers will be published in our *Journal* later this year so no excerpts will be included here.

(Australian N. & I. Bureau)
Alice Girard and Marie Jahoda

The Sections

As they registered, each participant was requested to choose one of the four sections — nursing education, nursing service, economic welfare or public relations. By far the largest number chose nursing education, though each of the other sections numbered their participants in the hundreds.

Going to Section sessions

A total of thirteen papers were presented at these sectional meetings. In addition to the speakers, representatives of many countries were selected to form the panels that took an active part in promoting discussion and in answering questions submitted by the audiences. These brief summaries of the thinking presented to each section by the speakers will reveal that while there was little that was new, "a fresh view of an old panorama sometimes opens up new and useful perspectives."

Nursing Education

The objective is to establish a climate in which young women may be encouraged to think, to reason and to develop in professional service, in personal stature and in usefulness as citizens and as nurses. Education must be based on as well as inspired by a study of nursing itself. The development of skills in human relationship, communication and management must keep pace with advances in technical skill. Nursing offers scope to women of varying intellectual abilities and educational preparation. It is unique among professions since it offers programs at two, possibly three levels — all in the same environment. The nurse is a substitute for what the patient lacks in

himself in order to be an independent creature. It is a present-day dilemma that the farther she progresses in professional education, the farther the nurse seems to move away from the patient.

There are differences of opinion as to the role of the university in assuming responsibility for nursing education. Hospital schools are making progress in broadening their curriculum, controlling theoretical and practical education and achieving a separate school budget. It is difficult for hospital schools to envisage a more comprehensive course that is not also increased in length. Nursing research is needed to show how present courses may be both strengthened and shortened. Not only should national groups get together to discuss the type of inquiry into nursing education we ought to have but these national programs should be discussed internationally to share the best of all the thinking.

Nursing Service

Our pattern of service has become more complex and scientific as we are called upon to nurse patients whose health problems are concerned more with the stress and tension of modern living than with diseases of bacterial origin. Today, governments as well as individuals recognize the people's right to health. This preoccupation about health is one of the fundamental causes of the steady rise in the demand for nursing care. We all recognize that the shortage of professional nurses is not a passing phase. A change in thinking is required so that all so-called non-nursing duties become the responsibility of personnel with less training. When the shortage of well qualified nurses becomes acute, it may be a real menace to the profession unless leadership, forethought and planning are recognized as needs by the nursing organization.

The trend to specialization in nursing service is also a threat to the profession as a whole. We must recognize this trend and give specialization every encouragement, providing we do not allow ourselves to lose effective unity because the individual groups grow away from each other. In large countries, distance and lack of

A coffee break

funds to maintain adequate communication between all the small groups make it an urgent responsibility for the national professional body to keep in close touch with each segment of its organization. The usefulness of an official journal for this purpose is very evident.

Public Relations

Both nursing education and nursing service are very dependent on effective communication — between nurses and their patients, with all of the other members of the health team, with the families of patients and with the community as a whole. Few nurses understand all of the skills and avenues of communication so they should be taught how to teach, how to interpret, in their basic educational program. The general public's understanding of nursing objectives, endeavors and problems will increase in direct proportion to the use that is made of these skills.

Business realized long ago that it is not enough to do a good job. It must be shown to as large a number of people as possible that a good job is being done. Professional organizations must project an accurate as well as a favorable image on the public consciousness. Nursing must not be afraid of controversy. Evolution is achieved only in the face of it. All communications media are sympathetic if they are approached with candor and lack of concealment. Nurses should make the first approach when faced by criticism rather than wait to be approached by a subconsciously sceptical reporter.

Economic Welfare

Genuine interest in and concern for the economic well being of nurses in all parts of the world is a recent devel-

Morning snack

opment. This section considered some of the problems to be overcome in establishing suitable standards of living, working conditions and remuneration, particularly in the less highly developed countries. The international aspects of such a program placed a considerable degree of responsibility on the professional nurses' associations of each member country to work for the improvement of existing conditions.

The Student Nurse Group

There were 223 students, two of them male, who met together at official and unofficial sessions to exchange ideas and compare teaching programs, working conditions, personnel relationships, responsibilities, allowances, social activities, and so forth. The groups were usually small and changing but a bond sprang up between them as they realized that though there were striking differences, their basic aims and hopes were the same.

One business meeting of all students was held to discuss the International Student Nurses' Unit, as provided for by the ICN in 1957. Miss F. Beck, director of the Nursing Service Division of ICN presided. The question of importance was this: Did the student associations of Australia, Sweden and the United States wish to join the International Unit at this time? If so, did they wish to elect a president?

After considerable discussion, which was open to the entire group, a decision was reached. Since no representative was present from Sweden, the other two countries decided to postpone their acceptance of membership until 1965. They felt that they were unprepared to meet the complexity of an international structure or to meet the financial obligations involved. The four-year interval between ICN meetings seemed too high a hurdle for students who graduate at the end of three years.

Ceremony of Admission

By five o'clock Friday afternoon, the auditorium was again packed with nurses as the formalities of admitting the new countries to membership began. A tremble of excitement ran through the immense crowd. With obvious regret, President Agnes Ohlson announced that, due to pressures beyond their control, the nursing representatives of four national associations — Egypt, Jordan, Mexico and Poland — were unable to be present. Their membership was confirmed *in absentia.*

Then, as the General Secretary called the name of the new member and the sponsoring escort, with her flag carried high by a uniformed student nurse, the representative of each country came slowly up the long centre aisle to music provided by the R.A.A.F. band. After being greeted by the President, both the sponsor and the new member each spoke for two minutes. It was a proud and impressive moment for all.

At the close of these ceremonies, Miss Bridges was presented with an illustrated book of letters from all of the member countries. During her 13 years as the general secretary, 32 national associations have joined the ICN.

The Closing Session

There was an acute awareness that the 12th Congress was drawing to a close as the audience gathered, almost silently. Already, many exhibits had been dismantled. Many participants had said goodbye on the previous evening. Miss Ohlson called upon Dr. Jahoda to give her impressions of the week's deliberations.

> It had been something like sitting in for a week at sessions of the United Nations, without any of the political overtones. In some ways the International Council of Nurses faces more serious problems than the U.N., for though nursing can span international boundaries it does not have any power

to adjust or mediate conditions as they exist. National nursing associations must act within the culture of thir own lands and must not let differences show through in their discussions. How can the ICN recognize these differences yet plan and develop programs internationally? This problem faces each administration.

What is the function and value of an international organization? Its primary purpose is to enable countries to help each other develop. Yet, giving and/or receiving assistance presents many difficulties. Even with all the goodwill in the world, givers tend to be patronizing. Student nurses have a clearer insight into how to help each other than do many graduates. A giver expects gratitude, appreciation and liking — yet one can come to *hate* a giver. Receivers must learn from the ground floor up. A congress such as this eases the route. Each delegate can learn something from the others.

Dr. Jahoda was favorably impressed by the level of discussion, the thoughtfulness and clarity with which ideas were expressed. "But," she asked, "has the Congress given individual nurses sufficient opportunity to participate? Too many papers have been *read.* Since they were all printed beforehand, why could they not have been given to the participants early in the week, then many, many small discussion groups could have been organized so that everyone had an opportunity to talk things over."

"There is one grave danger in a Congress such as this. An immense goodwill has been built up during this week. This goodwill could become an end in itself unless precautions are taken. Goodwill is only a means to face problems with vigor and success. The ultimate test is how effectively the ICN reaches its real objectives."

In her farewell address, Miss Ohlson posed several challenging and far-reaching questions. She pointed out that in order to progress we must continually evaluate and analyze the work being carried on by the ICN in the interest of progress.

Is the ICN fulfilling its true role?
Could roles be made of greater significance? Can we delegate responsibility?
Do we use colleagues with unique capabilities efficiently?
Do we listen to the public?
Do we communicate effectively?

Then Miss Ohlson gave the Watchword for this coming quadrennium — ***Inquiry.*** It was an amazing coincidence! As Mlle Clamageran, now wearing the chain of office as president, began to read her prepared address she prefaced it with the remark that she had been in complete ignorance as to the new Watchword until a few moments before. For our new international president spoke of her conviction that the ICN must press forward boldly in a program of research and inquiry!

Finale

Social affairs were numerous and interesting. Two of them were open to all Congress participants — a buffet dinner with the Royal Australian Nursing Federation as official hostess, and International Night on the last evening. The latter was a stirring close to Miss Daisy Bridges' years of service and camaraderie. Following the presentation of a gift on behalf of the ICN, Miss Bridges concluded her thanks with:

God gave me work until my life shall end,
Life, till my work is done.

MARGARET E. KERR

SUN WORSHIPPERS, BEWARE!

WM. D. STEWART, M.D., F.R.C.P.(C), JULIUS L. DANTO, M.D.
and STUART MADDIN, M.D.

"Old" skin, at an early age, may be the punishment for over-exposure to the sun.

A DEEPLY-TANNED SKIN is traditionally associated with good health in the minds of the public. This is probably because athletes, occupied with outdoor activities, often are tanned in association with their obvious good physical condition. There is no other relationship between suntanning and general physical condition. The only good that is derived from a session in the sunlight is the cosmetic result. Apart from the necessary brief exposure to ultraviolet rays for the synthesis of vitamin D (without the necessity of tanning) the effect of sunlight on the human epidermis is largely harmful. Exposure to sunlight results in both acute and chronic skin damage, sometimes of serious degree.

Uncosmetic effects

Individuals vary in their reaction to sunlight and the degree of burning they may experience. Blonds, redheads, and other persons with fair complexions are usually more prone to sunburning. This tendency is related to the thickness of the skin as well as the amount of pigment in it. Since tanning is simply a protective mechanism to shield the skin from the harmful effects of the sun's rays, those skins least protected by pigment or by thickness of the keratin layer, are subject to actinic or sun radiation damage. People who are the most subject to sunburning from short, intensive exposure, are also prone to the permanent effects of long-term exposure to excessive amounts of sun. They develop "old" skins long before they should. The result is an inelastic, prematurely senile skin, that clearly shows excessive wrinkling, atrophy, and thinning, and large numbers of enlarged superficial blood vessels (called telangiectasis). There may be abortive attempts at pigmentation with freckling, as well as areas of pallor or depigmentation. Such permanent changes are produced in persons with fair complexions who have spent much time in the sun for purposes of tanning because of their occupation or geographic location. We, in Canada, are less subject to these disorders than persons living in the southern United States or other areas with much sunshine. We do, however, see a surprising number of people with marked actinic effects even in this country.

The authors are dermatologists in Vancouver, B.C.

Harmful effects

Other actinic effects arising from long-continued sun exposure are more serious and include premalignant and malignant lesions of the skin. These classically occur in the exposed, midfacial area from forehead to mouth, including the cheeks, temples and ears. The backs of the hands are also sites of predilection. The premalignant lesions are called senile keratoses and are characterized by small, crusted and flaking lesions that persist. Approximately one quarter of these lesions may eventuate in skin malignancy. They are rarely found in anyone under 40 years of age, despite the degree of sun exposure, but are found in increasing numbers in people beyond that age.

Skin malignancies are often of the type that do not metastasize or cause damage, except for erosion in the immediate area of the lesion. They may enlarge locally and damage adjacent structures, but do not spread to distant sites. They often take the form of small, flesh-colored or pearly-white, elevated lesions with or without central ulceration. The lesions have elevated rounded borders and often are not inflamed.

The more dangerous metastasizing skin cancer is rather less common and can spread if not treated within a reasonable time after its appearance. From the time of their first appear-

ance, skin cancers of this type usually give the patient adequate time to see a physician and have the lesion successfully treated before serious complications develop. It is imperative, however, that suspicious skin lesions be examined and removed, if indicated, upon their first appearance. The metastasizing lesion begins as a small, flesh-colored or reddish brown nodule which gradually enlarges. There may be ulceration, with intermittent oozing or bleeding.

There are also a variety of skin disorders resulting from sunlight that may occur even in easily tanned and thick-skinned persons. These include:

1. *Lupus erythematosus* is a disorder of protein metabolism that may occur as a localized skin form or may effect any organ in the body. It can be fatal in its severe, generalized form.

2. *Porphyria* is a disease associated with dark red urine, large blisters or bullae on exposed areas and sensitivity to sunlight.

3. *Allergies to light* characterized by hives, eczema and other varied types of skin eruptions. These are always associated in point of time with a recent sun exposure.

A group of drugs formerly developed by the armed forces, for use against malaria have been found to be helpful in the treatment of diseases caused or made worse by sun exposure. With their careful use in selected cases, hope can be given to patients with these debilitating and severe disorders. Conditions associated with allergic reactions to sunlight can often be controlled by use of antihistamines.

Finally, the development of premalignant and malignant lesions by long-continued, excessive sun exposure may be halted by protection or avoidance of sunlight. Removal must be accomplished by local electrosurgery and curettage, or in selected cases, localized and carefully shielded x-ray.

Protection and Prevention

Sun-screening lotions and creams, may depend for their effect either upon their opacity (powder content) or upon specific chemicals which filter out certain wave lengths of the sun's rays. They should be used by persons susceptible to the damaging effects of sunlight on their skin, whenever they are outdoors in sunny weather. Persons with blue eyes and fair complexions and little tanning ability are well advised to forego the current fad for sun-worshipping and protect their skins by the reasonable use of opaque cosmetics. Persons with early changes of long-term sun exposure (sailors' or farmers' skin) should have all new or suspicious lesions examined and biopsied for further microscopic examination. They should also have periodic, preventive medical examinations even if no new lesions are apparent to them.

A program of graduate study in nursing to focus exclusively on clinical practice of medical-surgical nursing, will be inaugurated on Sept. 5, 1961 by the New York Medical College Graduate School of Nursing.

The program is intended to meet the growing need for highly skilled nurse clinicians in specialized fields which are receiving increasing attention in modern medicine, such as cardiovascular diseases, metabolic disorders, and afflictions of the chronically ill and aging.

The one-year course, divided into three consecutive 16-week semesters and leading to the degree of Master of Science is open to registered professional nurses who hold Bachelor's degrees.

Further information may be obtained by writing to New York Medical College, Flower and Fifth Avenue Hospitals, Fifth Avenue at 106th Street, New York 29, N.Y.

* * *

What is an idiot? A person who is mentally defective? By modern definition, yes: In precise terms, idiocy is a degree of general mental deficiency, and, in slang, an idiot is one who behaves foolishly.

The Ancient Greeks, who gave us the word, were more specific, however. To them, an idiot was one who took no interest in public affairs and shirked public responsibility and office. When one recalls that "democracy" is also of Greek origin, and that the Greek system of government conferred power and duty on every citizen, it becomes apparent that the difference between their usage of "idiot" and our slang usage is not very great. *The Lethbridge Herald*

Roles That Sicken and Transactions That Heal

SIDNEY M. JOURARD, PH.D.

If you are still wondering what comprehensive nursing care really entails, then read this article.

THERE is growing reason to suspect that hope, purpose, meaning and direction in life produce and maintain wellness, even in the face of stress, whereas demoralization by the events and conditions of daily existence helps people become ill. Schmale[1] found, for example, that 41 out of 42 patients admitted to a general hospital during a 23-day period showed evidence of feelings of helplessness or hopelessness shortly before the onset of their diversified diseases. This loss of morale was typically associated with a disruption in the relationship of the patient with a significant other. Schmale reported that such feelings of helplessness or hopelessness may actually set the stage for illness to occur when it does.

In a different study, psychologist Arthur Canter[2] was able to discriminate suicidal from non-suicidal psychiatric patients, and between each of these groups and a group of normals on the basis of scores derived from the well-known Minnesota Multiphasic Personality Inventory. The questionnaire items on which the scores were based had reference primarily to diminished self-esteem. Canter called his scale a measure of morale loss. Scores on the Morale Loss Scale further differentiated between fast and slow recovery from brucellosis, and between subjects with histories of frequent medical illness and those with little illness in their backgrounds.

Both these studies represent attempts to verify scientifically impressions long held by physicians, nurses, and psychologists — that one's attitude toward life and self are factors both in the onset of illness and in the recovery therefrom. These two studies can serve nicely as a point of departure for a discussion of a revolution that is going on in current thinking about health and disease, a revolution that has profound implications for nursing practice. Clearly it *must* have such implications, since the theory of disease and health that is extant during a given epoch more or less serves as a guide to efforts at rehabilitation.

Dr. Jourard is associate research professor at The J. Hillis Miller Health Center, University of Florida, Gainesville.

Dispiriting Events

Schmale's and Canter's studies suggest that if we want to find psychological factors that predispose toward lowered resistance to illness, we should look into transactions and events in everyday life that produce a sense of hopelessness, such as a loss of the sense of identity and self-esteem, loneliness-producing events or ways of life, or more generally, what I shall call hereafter dispiriting[3] events. Let me propose as a general definition that events, relationships or transactions that give a person a sense of identity, of worth, of hope and of purpose in existence are "inspiriting," while those that make a person feel unimportant, worthless, hopeless, low in self-esteem, isolated, frustrated, which make him feel that existence is absurd and meaningless, are "dispiriting." The hypothesis is that dispiriting events render an organism vulnerable to the always present forces of illness, while inspiriting events mobilize the forces of wellness latent in all organisms.

Sickness, whether mental or physical, seems to be one of several ways in which people express protest[4] against a way of life that will not support wellness. People become ill, not just because of germs, viruses, trauma, or stress, but because these assaults fall upon receptive hosts. Hinkle[5] has adduced evidence to show that the so-called "normal" ways of life in

which most of us live are interrupted by sickness about 10 times a year. The sicknesses include headaches, colds, flu, diarrhea or constipation, or more serious ailments. Something about the normal or usual way of life must dispirit average people periodically, since they become ill with such regularity. Let us explore normality and seek to identify those aspects of being an average person which dispirit and hence permit illness to arise.

All is Not Well

Organisms have self-regulating, homeostatic mechanisms built into them such that when balance is disrupted, signals are emitted. These signals elicit reflex and behavioral compensatory responses that restore dynamic equilibrium. At the human level, many of these signs of disruption (I call them "all is not well" signals) reach conscious awareness. They are capable of being discriminated, and are identifiable as pain, depression, boredom, frustration, anxiety, or just generalized malaise. By and large, these signals will arise in weak intensity at first as a person pursues his customary round of everyday activity, and hence are usually ignored. They are most likely to be ignored when they are of low intensity, or, if they arise more intensely, in people who are unable to notice what is going on inside of them.

In our culture, we are trained from an early age not to pay too much attention to our inner selves, to our own feelings, wishes, and needs. We are urged instead to listen to the commands of others, or to the promptings of conscience.[6] By the time most of us reach adulthood, we have lost intimate contact with our actual selves. Indeed, we only know that our real needs and feelings are being ignored when we begin to feel unexplained anxiety, boredom,[7] irritation, or a sense of emptiness in our existence. But we seldom know *why* we feel these things. As a matter of fact, pressures to play our various roles in the "proper" way actually foster increased self-alienation.[8] If we have been taught to believe that only certain kinds of wishes, feelings, and thoughts should go on inside us, then when we look inside and find other horrendous wishes and feelings that life has induced in us, we turn away from ourselves in horror!

When "all is not well" signals are thus ignored, the person goes on doing whatever it was that produced the low-level discomfort signals, instead of giving pause and seeking to change his conduct to do better justice to his needs. If the person's everyday activity is authentically not good for the integrity of his total personality, then the assault on his wellness continues inexorably. Consequently, more intense signals will eventually arise. The person will become so full of pain, boredom, anxiety, that he cannot continue his customary round of behavior — the very round that was sickening him. When he thus stops his usual work and play, when he temporarily resigns his normal role-obligations as parent, spouse, worker, friend, or playmate, we say he is sick. He may then say, "I can't carry on as usual because I am now sick." It might be closer to the facts if he said, *"I am sick because I carried on as usual."* Of course, it is also true that *abrupt* changes in roles, relationships, surroundings or ways of life that had previously sustained wellness will dispirit people and thereby promote illness.

Roles That Sicken

I suspect that gradual dispiritation is more common and less noticeable *because* of its gradualness. The *usual* round of activity gradually dispirited the person, resulting in lowered resistance to infection, lowered ability to rebound from the effects of stresses, and lowered ability to suppress the primitive psychological reactions latent in all of us, which, when manifest, we call mental illness. In my opinion, *it is this felt necessity to play roles in a standard, procrustean manner, withholding and suppressing all the while our own spontaneous and idiosyncratic selves, that gradually dispirits us and makes our bodies fertile gardens for disease.*

When people feel compelled to suppress their identities in order to seem respectable to themselves as well as to others (consciences are villians here),[9] important consequences follow. First, there is a loss of sensitive awareness

of one's inner experience. We already have indicated how this can permit low-level signals of incipient illness to be ignored. Another outcome of such suppression and repression of spontaneous inner experience is that added stresses are imposed on organisms already burdened with the normal stresses of everyday life. I say this because it consumes energy to suppress behavior. When people are wearing masks, as they do, dreading to be known, then *other* people become chronic sources of threat and stress to them. When people are obliged to play the role of spouse, friend, child, or worker in some *stereotyped* way, withholding their inner selves from the gaze of others, it inevitably follows that other people will never really come to know them. Remaining unknown may be a relief, but it has its price. How can anyone know you unless you make yourself known to them through full and free disclosure?[10] How can anyone meet your needs, for example, if you will not make them known, because of fear of criticism or because of guilt? How, for that matter, can you know your own needs, if you have become estranged from your real self? If you do not know what you really want or need in order to find satisfaction and meaning in life, it follows that neither your behavior nor that of another loving or well-intentioned person will ever truly "hit the spot." In short, rigid enactment of roles must inevitably produce both unwanted loneliness — the feeling of not being known or understood[11] — and gradual dispiritation following the failure of behavior to bring rewards.

There! I believe I have just finished describing what might be called the "normal" personality of our time. He is "normal" only in the sense of being typical, not normal in the sense of manifesting joyous and abundant health utilized to pursue a meaningful, purposeful, satisfying existence.

Skinner has shown that when an animal, such as a rat, is trained to press a lever at a certain rate in return for periodic rewards of food, he will keep on responding so long as there remains hope of reward. Even the animal will stop, however, when the boring activity of lever-pressing fails to pay off in rich satisfaction. So it is with people. There are many parallels to hopelessly unrewarding lever-pressing among humans — for example, drudgery and lack of challenge in work, nagging loneliness and emptiness in personal life, and rigid, impersonal roles that destroy identity and spontaneity in everyday dealings with family or friends. We learn a repertoire of roles and behavior patterns called "personality." We perform this repertoire in our everyday lives, not because it satisfies our needs, but rather because it is socially acceptable. If it fails to do justice to our assorted wishes and needs, then inevitably we will become lonely, bored, hopeless or depressed — in short, dispirited. In this condition, we are more prone to illness resulting from the stresses and pathogens that are always with us.

Sickness and Wellness

The real question shouldn't be, why do people get sick? Rather, we should ask, why aren't people sick all the time? I think we might find that those people who seldom become sick are the ones who have found ways of life that permit them to be and to express their inner selves; ways that yield purpose, meaning, hope, interest, and reasonably rich satisfactions of needs for affection, love, sex, status, and achievement. Yet they are reasonably respectable in their conduct. The healthier people, when they find their present ways of life dull, frustrating, or tedious, pay attention to their "all is not well" signals. *They change what they are doing, including their ways of behaving with others.*

But this is the joker! It is difficult and anxiety-provoking to change what one is doing, to change one's way of transacting with others. Powerful forces from within and without tend to restrain change, and so most of us keep up the way of life that has been slowly "doing us in." Therefore, we become sick, and it is usually with some measure of surprise. It is still an unsolved question why the sickness is "physical" for some and "psychiatric" for others. I am coming to suspect that those who are often physically ill are people who commit "altruistic suicide" by slow degrees. They are slowly destroying their

bodies, as it were, for the preservation of their roles and the social systems in which they regularly participate. They are victims of their sense of duty. The psychiatrically ill seem to resemble rebels without courage or effectiveness.

Being sick is a temporary respite from the dispiriting conditions of our existence up to the onset of the illness. Incidentally, if it seems to a patient that his usual life, the one that made him sick, cannot be changed, he may never get well. Why should he? Or if he does recover but then resumes his usual life, he'll be sick again before long. As he leaves the hospital, we could safely say, and mean it, "Hurry back." If illness has not proceeded too far, when we get sick we merely get int our own beds. If sickness has proceeded to a point where it seems that the body or mind cannot restore itself unaided, we then take to the hospital, and let the experts have at us.

Faith and Healing

At the point where people have become sick, I want to make a digression. Medicine has made much progress in describing and labeling the various syndromes of illness. Much progress has even been made in identifying the proximate causes of these syndromes, and devising pharmacological or surgical methods for neutralizing them. But, it is estimated that except for perhaps 15 per cent of all illnesses, rest or change alone will permit the organism to restore itself to the premorbid level of functioning. Official medicine and the media of mass communication have not sufficiently publicized the healing powers of changed conduct, changed surroundings, and rest. They seem to place more faith in the healing powers of drugs. I have yet to turn on my TV set and hear the announcer say "What do doctors recommend? In a recent survey, three out of four doctors recommended fishing, or golf, or love, as remedies for nagging backache, headache, etc.." Who would sponsor such announcements, anyway?

The public has been so brainwashed that, when ill, many people do not feel that they have been treated unless medicines have been prescribed and ingested, or unless they have been cut open. In spite of efforts to minimize the so-called placebo effect of drugs and other therapeutic measures, it has not been possible to state with scientific confidence that medicines ***heal*** people. When the evidence is assessed impartially it seems likely that the patients' *faith* in the healing powers of the doctor, his rituals, his medicines and his aseptic temples, is the true medicine. How else can we account for the many authentic instances of gravely ill people responding to prayer; to proximity to shrines; to chiropractic procedures; to Christian Science; to the mumbo jumbo of voodoo witch doctors; to sweet, pink pills, and to any other symbols of healing power in which they may place their faith?

We need to devote our best scientific talent to intensive investigation of the psychophysiological mechanisms that are brought into play when sick people have their faith and confidence inspired by supposedly healing symbols and rituals. Actually, we know that healing is rooted in the biological structure of the organism, not in drugs, surgery, or manipulations. We need to identify what might loosely be called the "healing reflexes," some of which are doubtless psychological, and determine what conditions will bring them under the control either of a therapist or of the sick person himself. If we had a program devoted to the identification of the factors in the so-called placebo effect, to understanding the relation of faith to healing we might learn much that is new about illness and recovery.

Actually, the failure of health scientists to devote their truth-yielding research efforts to the study of how placebos, Christian Science, chiropractic techniques and the symbols of medical know-how all promote healing is a fantastic oversight, attributable to what I do not know, unless it is to the *zeitgeist*, or to the subtle brainwashing effects of propaganda from drug companies. Physicians, since time immemorial, have noticed that placebos have healing effects. Rather than investigate them rigorously, they have used them, but shame-facedly, viewing the patients who respond to them as stupid, suggestible, not really sick. Research indicates that the physiological effect of drugs or surgery accounts only for *part* of the total variance in healing,

and that perhaps a greater proportion, if not all, may be accounted for by the attitude toward, and faith in treatment manifested by or inspired in the patient.

Interpersonal Relations or Manipulations?

If it is true that performance of roles that dispirit contributes to the onset of illness in patients, and if it is true that the gratification of needs, being known and cared for, being identified and treated as oneself, and being permitted to be oneself are factors in the attainment of wellness, then nurses have a job carved out for them. How can they relate to patients so that the latter will feel known, will feel free to be themselves? So that they will feel that they are *not* being treated just like everyone else? So that patients will enjoy rich gratification of hitherto thwarted needs? If inspiriting events foster healing, how can nurses learn to relate to patients in ways that "inspirit" them?

The profession has emphasized the importance of "good interpersonal relationships," but careful study of what so-called interpersonal experts among nurses actually do, reveals that they institute clever manipulations which make the patient do what he is supposed to do. In short, much of the contemporary interpersonal competence among nurses seems to entail suaveness in *getting patients to conform to the roles they are supposed to play in the social system of the hospital, so that work will get done faster and so that the patients will be less bother to care for.* It would seem that there has been a movement afoot in the nursing profession to train nurses to teach patients how to become good "organization men." Their behavior will be good for the organization of a ward, but not necessarily good for the attainment of identity, or even of wellness! My profession, psychology, has, in a sense, sold nursing the same bill of goods that was so eagerly purchased by educators, advertisers, brainwashers and politicians, who have a vested interest in controlling the behavior of others for the good of an institution but not for the good of the individual. We have sold such techniques as operant conditioning, propaganda, hypnosis, smiling, and other cold-blooded methods for inducing liking or obedience.

There is something self-defeating about the practice of treating people who have become ill, in part because of rigid, demoralizing role requirements, by casting them in equally rigid role requirements — those inherent to the patient role. My anthropologist colleague, Carolyn Dickinson-Taylor, writes in this connection,

> . . . (There is) a peculiarly 20th Century expedient of adjustment — the *stripping technique* (which) reduces the individual to an interchangeable unit. These mass interchangable units are then labelled in terms of their function: average student, consumer, patient, doctor, nurse, etc.
>
> The first step in the process of stripping is removal of the old frame of reference (or identity) . . .which is accomplished by means of administrative procedure. In the case of the patient, the procedure is called "admissions" . . . for the doctor or nurse, it is called medical school or nurses' training.

Mrs. Taylor concludes her paper with the observation that not only patients, but also doctors and nurses have been subjected to sociological sheep-shearing, to a shearing of their identities that has made them over from persons into interchangeable parts. "Patient care and cure must suffer," she says, "in direct proportion to the effectiveness with which training and administrative procedures have stripped people . . . changing them from human persons into doctors, nurses and patients." I might add that the wellness of doctors and nurses is jeopardized when they play *their* roles with chronic impersonality.

Recently, one of my nursing colleagues gave a report in a conference about an "obnoxious" patient. This woman was able to make her peculiarities known to almost every doctor in town and to all of the staff of our own hospital. She was demanding; she insisted on endless reassurance; she didn't like the way she had been treated. In short, she was generally regarded as a "crock" and as "a pain in the neck." There was general agreement among the nurses that this woman was obnoxious. Many suggestions were made concerning how she

should be treated. These ran the gamut from having her referred to psychiatry for shock treatment — an excellent way to trim the rough edges and the identity from a person — to various slick suggestions as to how she could be made more reasonable.

I will agree that people in the raw, people who don't play the game the way that they should are "difficult" for most of us. But does this mean that we should only attempt to help those people who "deserve it" because of their "good behavior?"

Transactions That Heal

Somehow, if nursing is to rise to its potential status in the healing arts, nurses must grow to the point where they become able to establish communicative contact with a broad range of people including those who seem obnoxious. It would seem that such contact is a *sine qua non* for helpful nursing transactions. I am coming to believe that it is the peculiar privilege of nurses to play, not just *an* important role in healing, but possibly *the* important role. Nurses, when they do not run from the bedside into impersonal administration are potentially with patients more than doctors or even relatives. If they can permit patients to be themselves in their presence and not be driven away by whatever the patients bring forth when they are thus granted freedom of self-expression; if they can communicate profoundly with patients, so that the latter overcome a deep sense of loneliness that seems to be part of illness — an outcome if not a cause; if they can help patients feel that here is someone who cares, to whom their feelings and wishes matter, they may so restore identity and morale to them that they get well *in spite of* the usually impersonal regimen of hospital life.

If "inspiriting" events foster healing, and if close communicative relationships with patients *are* inspiriting, then it follows that every transaction in which a nurse has established contact with a patient, so that he knows she knows what is on his mind, will foster healing. If acknowledgement of requests, however bizarre, immature, or spoiled they may show the patient to be, is inspiriting, then it follows that every time a nurse hears a request, takes it seriously, tries to understand it, and does her best to meet it she will foster healing. Automatic bedside manners, stereotyped ways of playing the nurse role that thrust the patient back into the dispiriting anonymity of the patient role, cannot be inspiriting. Somehow, nurses, who can be crucial healers, must learn to *create* their roles guided by cues provided by the peculiarities of each patient. There is no evidence to suggest that the role-definition of the nurse as acquired in school or described in the "line-item" budget will be necessarily healing for the patient or healthy for the nurse. Perhaps the most general and vague, yet accurate way of proposing how nurses can be more effective healing agents or catalysts is for them to struggle to establish personal contact with the "obnoxious" patient, who, like most of us, may feel condemned to solitary confinement in the prison of his own skin, and role.

I think that nurses will better learn the art of role-creation, a new role with each patient, when two things take place. One is a change in hospital structure so that nurses' roles are not so tightly defined by the job descriptions of administrators. Nurses should be freed from many of the chores that serve mainly to keep the wheels of administration functioning smoothly. The second change must come from *within* any particular nurse. She must be able to profit from increased freedom "to be." In the University of Florida teaching hospital, many non-nursing functions have been assigned to clerks, unit managers and nursing assistants. This frees professional nurses for more personal contact with patients. It would be foolish to say that this hospital is without problems, but some progress has been made in the direction of freeing nurses to establish the kind of personal contact that inspirits patients.

Interestingly enough, the anthropologist employed there noted that the nurses, when their previous clerical tasks were taken away, reacted much like amputees with an hallucinated phantom limb! So the anthropologist consulted with occupational and physical therapists to find out how they helped people who had lost a limb to mobilize their resources and even

emerge from the experience more fully functioning than they were previously. The insights gained proved helpful in the rehabilitation of nurses *to nursing* following the "amputation" of such functions as laundry sorting, record keeping, and the like. Another factor that seems to help nurses become freer to establish the contact and the relationships which inspirit is a kind of inner freedom that comes from effective psychotherapy — the freedom and courage to be oneself! We have made some progress in this direction with our faculty through three years of inservice education in which all participants have been encouraged and permitted to be and to disclose themselves on all manner of topics. The dividends in empathy, resourcefulness, and enhanced ability to establish contact with others have been considerable. Our faculty members are excellent nurses as well as teachers. They seem expert at inspiriting patients as well as students.

Let me conclude with a prophecy — that at some future time, more people will have learned to notice their "all is not well" signals, and will have the courage to change their behavior *before* they become sick. Those who *have* become sick may be treated less with drugs and surgery, and more with human relationships that heal.

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A new health directory has been published by the Graduate School of Business and Public Administration at Cornell University. It is titled *Health Organizations of the United States and Canada: National, State and Regional.* The work is the first complete and up-to-date directory of voluntary associations, professional societies and other groups concerned with health, medical, hospital, pharmaceutical and related fields.

Details for each organization include address, names of principal officials, purposes and objectives, finances, programs and activities, publications, prizes and awards, meeting dates, affiliates, etc. A particularly important feature is the complete and detailed subject index of all the national and regional bodies.

The work contains 196 pages and is a bound volume. The price is $10. It is available from the Publications Section of the Graduate School of Business and Public Administration, Cornell University, Ithaca, New York.

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To clean the kettle, fill it with water and two tbsp. of ammonia. Let water come to a boil, then simmer for 15 minutes; empty and wash thoroughly.

* * *

Sickness drives charity into the flesh.

— DE GONCOURT

BLEEDING DUODENAL ULCER

BARBARA CROW

Twenty-five days are but a moment in a life-time! The events of these days were to influence a man and his family for the rest of their days.

The Patient

MR. VERNON was admitted to hospital with a provisional diagnosis of bleeding duodenal ulcer. He was a 28-year-old Canadian accountant who worked and earned a moderate income in a large factory. He was the father of two children of whom he was very proud. He always kept quite busy at home, with his hobbies of reading and carpentry, as he hated to remain idle for long. He had a very pleasant, quiet personality and was very cooperative, although he was obviously tense and other members of his family appeared to be worriers.

Present Illness

Mr. Vernon had been in good health until four days prior to admission when he thought he had the "flu." He had been vomiting, had noticed some blood in it, and also had had diarrhea. The doctor visited him at home and found him quite pale. On physical examination there was no glandular or thyroid enlargement, his chest was clear, his heart beat regular, and there was no abdominal tenderness. Examination of his stool, which was quite tarry, was positive for blood. The doctor advised Mr. Vernon to go to hospital to confirm the diagnosis and to receive treatment.

On admission, Mr. Vernon seemed a little frightened of the hospital. This was the first time he had been a patient and he did not know what to expect. The nurse who admitted him tried to allay his fears, and make him feel "more at home" by introducing herself, and being friendly and cheerful. She introduced him to the patient in the next bed, showed him his locker and closet, and showed him how to call a nurse if he needed anything. His temperature, pulse and respirations were 100° - 100 - 22. His blood pressure was 138/70.

Mr. Vernon seemed a little embarrassed about having his clothes listed but when it was explained to him that it was done to safeguard his personal belongings, he seemed more at ease. It was very important to make him feel that he would be well taken care of. This was the first time that he had been away from his family, and the hospital and its routines were completely new and unknown to him.

The Disease

When looking after a patient who has a peptic ulcer, the nurse should know something about the disease in order to give effective nursing care. A peptic ulcer is an excavation in the mucosal wall of the stomach, pylorus, or duodenum. It is due to erosion of a circumscribed area which may extend as deeply as the muscle layers or the peritoneum. Ulcers occur most commonly in the first portion of the duodenum and pyloric portion of the stomach.

Pathology and Predisposing Factors

The etiology is obscure. Though many factors are probably involved in the development of a peptic ulcer, the erosion is caused by the digestive action of the enzyme pepsin because of increased gastric acid secretion. It is thought that a portion of the gastric mucosa is devitalized and is subsequently digested by the gastric juice thus forming a crater. There appears to be a relation to excessive emotional stress that causes accelerated acid secretion, hypermotility, hyperemia and engorgement of the gastric mucosa. Predisposing factors for recurrence are emotional stress, excessive smoking, and poor dietary habits, for example, eating spicy or acid foods. The disease tends to appear and recur in the spring and fall.

The doctor felt that perhaps the predisposing factors to Mr. Vernon's devel-

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Miss Crow, a student nurse at Brantford General Hospital, Ont., received a first prize award of $25 for this study in the Macmillan Award Competition.

opment of a peptic ulcer were his very conscientious attitude toward his work, and the fact that he did not seem to be able to relax, but worked most of the day. He usually ate fairly heavy meals and was fond of spicy foods. He was a moderate smoker. In addition, he was tense and, like the other members of his family, he tended to worry easily. There was no history of peptic ulcers among his relatives.

Symptoms and Complications

The main symptom of peptic ulcer is pain or a gnawing sensation, sharply localized in the mid-epigastrium. The pain has four distinct characteristics: Uniform quality; uniform location; a tendency to rhythmicity and periodicity with periods of remissions, and a tendency to become chronic. The pain occurs from one to three hours after meals and becomes progressively more severe towards the end of the day. It is relieved quite promptly by food or alkalis either of which neutralize the free acid. The character of the pain may be described as a dull, burning sensation; a feeling of emptiness or a gnawing pain which can become agonizing. Sharply localized tenderness is caused by gentle pressure on the epigastrium.

Vomiting is the second classic symptom of peptic ulcer. It is due to pyloric obstruction as a result of muscular spasm. It may or may not be preceded by nausea and usually follows a bout of severe pain that is relieved by ejection of the acid gastric contents. Other symptoms which may occur are: Heartburn; acid eructations; gastric distention; nausea; vomiting; excessive salivation; anorexia; weight loss; diarrhea; and anemia due to an associated gastritic and irritable colon. The only *sign* of peptic ulcer is slight to moderate epigastric tenderness.

As the ulcer deepens, it may erode a blood vessel and cause acute intestinal hemorrhage. The signs are: Apprehensions; restlessness; cold, moist and pale skin; increased pulse and respirations. Bleeding is manifested by hematemesis and tarry stools. If the hemorrhage is severe rapid blood replacement may be necessary to save the patient's life.

Another complication that may occur unexpectedly is perforation of the ulcer into the free peritoneal cavity. The patient has sudden, severe, upper abdominal pain which persists and increases in intensity. It is accompanied by vomiting and followed by collapse. The abdomen is extremely tender and boardlike. Signs of shock soon develop. Immediate surgery is necessary to close the perforation.

Mr. Vernon had only a slight gnawing pain in his right upper outer quadrant about two hours after meals. It was relieved by eating. He had been nauseated and had vomited a moderate amount of blood. Gross internal hemorrhage was evidenced by tarry stools. He also showed such signs of hemorrhage as extreme pallor, weakness, apprehension, and rapid pulse. There was no noticeable abdominal tenderness, but he had anorexia and diarrhea.

Treatment and Nursing Care

On admission to hospital, the doctor's orders were:

a) Gastric #1 diet; b) 2 tsp. of Amphojel four times a day; c) Tuinal gr. 1½ at bedtime if required; d) bed rest with bathroom privileges; e) hemoglobin estimation; f) each stool checked for occult blood.

Mr. Vernon's hemoglobin was only 30 per cent or 4.5 gm. per 100 ml. of blood as compared with a normal of 100 per cent or 15 gm./100 ml. His pallor, weakness, and rapid pulse showed that he had lost quite a bit of blood. Following the report 2000 cc. of whole blood were ordered, 1000 cc. to be given as soon as possible.

Intravenous infusion of whole blood is the most effective method of correcting a blood volume deficiency produced by hemorrhage from an ulcer. When a patient is receiving blood, the nurse has many responsibilities. Mr. Vernon was told in advance that he would be getting a blood transfusion. He became slightly apprehensive as he feared that his mother would worry about his condition if she saw him having it. He wondered if a transfusion was really necessary but he was reassured that he would feel much better and stronger afterwards.

Transfusion therapy entails a number of risks since a few of its potential complications cannot be prevented with absolute certainty. The nurse must watch the patient closely while he is receiving the transfusion. Pulmonary

congestion may occur if too much blood is given or if it is given too rapidly. Warning signs are cyanosis and dyspnea, and later, pulmonary edema with stertorous breathing, persistent cough and production of frothy sputum. Allergic reactions in the form of urticaria or pyrogenic reactions due to bacterial contaminates may occur. The most dangerous of all transfusion complications is the hemolytic reaction that follows the injection of red cells that are agglutinated by the plasma of the recipient. Symptoms usually begin within 10 minutes after starting the transfusion. The patient may complain first of chilliness, headache, backache or abdominal distress after which he suffers a shaking chill followed by a high fever. There may be a fall in blood pressure. The transfusion should be terminated immediately. To prevent the possibility of this reaction the blood is grouped, typed and cross-matched before it is given.

Mr. Vernon's infusion ran at 125 cc. per hour. He had no adverse reaction to it. He was glad when the transfusion was discontinued since his arm was sore from holding it in one position for so long. After the first 1000 cc. were given his hemoglobin was repeated and was found to be 54 per cent or 8.1 gm./100 ml. His color was much improved and he felt stronger. Another 1000 cc. of blood were given the next day, after which his hemoglobin had increased to 64 per cent or 9.6 gm./100 ml.

After the blood had been given and the pain from the ulcer had subsided, a gastrointestinal series was ordered. In preparing Mr. Vernon, it was necessary to explain to him that he would go to the x-ray department in a wheelchair at about 8:00 in the morning. He would be asked to swallow a white liquid so that the doctor could see the outline of his stomach by x-ray. He was told that he would not be able to drink or eat anything after midnight on the night before and that he would not have any breakfast until after the x-ray.

Fluoroscopic examination of the chest revealed no abnormality. The only abnormal finding was a small, active, posterior wall duodenal ulcer.

Medications

The drugs used in treating Mr. Vernon's ulcer were Amphojel and belladonna. Drugs simply create conditions which make it possible for nature to heal the ulcer. Amphojel, which is used to coat the stomach and duodenum, is a colloidal mixture of two essentially different types of alumina gel. The antacid gel stops gastric corrosion and the demulcent gel provides a prolonged, local protective effect. The chief action is chemical neutralization of the hydrochloric acid in the stomach. Its astringent effect helps to stop and prevent bleeding, but may also cause constipation. Amphojel is nonsystemic in action and hence does not interfere with the acid-base balance.

Mr. Vernon was given two drams of Amphojel four times a day, on a spoon and without water. It was given on a spoon because it is thick and tends to stick to the side of the medicine glass causing the patient to get less than the ordered dose. It was given without water since water dilutes it and inhibits its "coating" effect. Although Amphojel has a pleasant flavoring agent added, Mr. Vernon did not like the taste and described it as chalk. At first, he did not want to take it, but when he found out how well it relieved his pain, he took it with less resistance. After four days in hospital he had no further pain.

Four times a day, Mr. Vernon received belladonna, an anticholinergic drug given to suppress gastric secretion and thus increase the effectiveness of the antacid compound. Symptoms of toxicity, for which the nurse should be alert, include dryness of the mouth and throat, excessive thirst, difficulty in swallowing, flushed dry skin, rapid pulse and respirations, dilated pupils and emotional excitement. Mr. Vernon showed none of these toxic symptoms.

Diet

One of the most important phases of Mr. Vernon's treatment was careful dietary management. General principles for gastric diets are adequate nourishment, with frequent, small feedings to keep the free acid neutralized. No mechanically or chemically irritating foods or foods that stimulate gastric secretions should be given. A mechanically non-irritating diet is low in residue and free from substances that might cause an abrasion or irritation when coming in contact with the eroded surface of the ulcer. A chemically non-

irritating diet is free of all foods that tend to stimulate the flow of gastric juice, and hence irritate the inflamed and friable tissue. Examples of irritants are: Meat extractives found in broth and gravies; tea; coffee; hot spices; sweets; mustard; vinegar; pickles and acid fruits. Alcohol and tobacco are omitted for the same reason. Protein foods are desirable as they aid in healing the ulcer.

There should be a gradual, but ultimate restoration to an adequate diet. At first, Mr. Vernon received a gastric No. 1 diet — four ounces of equal parts of milk and cream every hour while he was awake. Since the pain did not persist during the night, it was not necessary for him to take it every hour during the night. However, milk and cream were left on his locker in case he woke up with pain. It was the nurses' responsibility to make sure that he got his feedings on time. Mr. Vernon did not like this diet as it was very monotonous. As soon as the pain subsided, his diet was increased gradually.

After three days the diet was increased to a gastric No. 2. He received six ounces of milk or a milk drink every two hours. In addition, between milk feedings, he received a small bland feeding every hour. Such foods as white toast, cream of wheat, custard, milk puddings, junket, plain ice cream, soft cooked eggs and creamed soups were used for these feedings. Since this diet lacks vitamin C, he was given three ounces of fresh orange juice daily, immediately following a feeding. Milk was at his bedside at all times.

A week later, his diet was increased to a gastric No. 3, which is similar to a bland diet. He received three meals a day plus nourishment in the morning, afternoon and evening. Foods that were added were decaffeinated coffee, weak tea, cooked strained apple, peach, pear, ripe bananas, white meat of chicken or turkey, white fish, sweet breads, crisp bacon, calves' liver, lamb chops, potatoes, macaroni, refined rice, strained peas, beets, beans, squash, asparagus and carrots. As previously, milk was on his locker at all times.

Finally, four days later, the diet was increased to a gastric No. 4. Now he was eating almost a normal diet. The foods he was not permitted were: carbonated beverages, strong tea or coffee; fresh bread, whole grain cereals; pies, fried foods; smoked, excessively fat, rare, or tough meats and sausages. Other foods to be avoided were meat broths, spices, tomatoes, cabbage, onions, turnips, nuts and seeds. By this time Mr. Vernon was getting used to his diet and enjoying his food much more.

Another important role of the nurse was to ensure rest, both physical and mental, since rest is essential to the healing of the ulcer. When Mr. Vernon was first admitted he was given complete bed care with the exception of bathroom privileges. At first, when he was so weak, it was necessary for the nurse to bathe him, but later, when he was feeling stronger he was able to do this for himself. He washed his own hands and face and cleaned his teeth before breakfast and after dinner.

The bath, back rub and a neatly made bed helped to make him feel more refreshed and relaxed. The room was well-ventilated, free from draughts, and kept as tidy as possible, with the things he wanted close at hand. The nurses tried to be as quiet as possible and avoided jarring his bed, banging into furniture, and talking loudly. At first, Mr. Vernon became quite restless lying in bed, since he was accustomed to being busy all the time. It was necessary to have some type of diversional therapy. Since he enjoyed reading the nurse gave him some books. He liked watching television and usually did this during the evenings. He enjoyed talking with the patient in the next bed. He usually slept for a short period in the afternoon.

He was given a back rub with rubbing alcohol and powder every four hours, to prevent the development of pressure areas on his back. Lying in bed all day can become quite tiresome so it was necessary to make sure he changed his position from one side to the other and to his back. He usually did this at least every two hours. Being able to walk to the bathroom also provided a change.

After the pain and nausea had subsided his activity was gradually increased until, by the time he was ready to go home, he sat in the sunroom most of the day except for a sleep in the afternoon.

To ensure complete *physical* rest, the patient must have complete *mental* rest. This is very difficult to attain but is especially important for a patient with peptic ulcer. Emotional stress causes accelerated acid secretion in the stomach which, in turn, aggravates the ulcer. When he came to the hospital Mr. Vernon felt quite insecure, bewildered and dependent on others for everything. He was quite embarrassed about being looked after by someone younger than himself. When he realized that the nurses had a sincere interest in his welfare and were willing to do anything for him, his fears were lessened. The nurses answered his light promptly when he called, and did not make him feel that he was a bother. At first, he felt quite lonely since he was cut off from his family and friends, but his wife, mother and a neighbor came to visit him every day, making him feel that they were truly interested in his well-being. One of the most important things the nurse could do to help him solve his problems was to listen to him with interest. By doing this, she helped him to solve his own problems.

Because of the unfamiliar surroundings of the hospital, a strange bed, and unusual noises, it is often difficult for patients to sleep at night. To ensure a good sleep Mr. Vernon was given a drink of warm cocoa and Tuinal gr. 1½ at bedtime to help him to relax. Tuinal is a barbiturate containing seconal and sodium amytal. It is a hypnotic that is used to induce sleep. Throughout his stay in hospital, he slept well.

Mr. Vernon was bothered by constipation. This was partly due to the astringent action of Amphojel and partly because he was not getting as much exercise as usual. On three occasions, it was necessary to give him one ounce of milk of magnesia. It was given at bedtime with good effect on each occasion.

Every other day a stool specimen was sent to the laboratory to determine the presence of occult blood. Chemical examination revealed that blood was present in the stools for 11 days following admission.

To determine whether the ulcer was healing, another gastro-intestinal series was performed. It revealed that the ulcer had fully healed and had left only a minor degree of deformity in the mucosal fold. Ulcers heal by the formation of scar tissue and the surface heals without mucosa.

The health teaching was very important to help prevent a recurrence of the ulcer. Not only was it imperative for him to realize the importance of the preventive measures, but it was equally urgent that his wife and family knew the significance of them. He was told that he should avoid anxiety-producing situations since they tend to precipitate a recurrence. He would have to adhere to a sound routine of hygienic living including regularity of habits in general; moderation in all pursuits; adequate daily rest; ample relaxation; and abstinence from smoking. It was difficult for Mr. Vernon to give up the latter.

It was important that he and his wife should understand fully the restrictions and significance of his diet. One day while his wife was visiting him the dietitian brought him a list of foods that he could and could not eat and explained the reasons. She emphasized that at no time should his stomach be completely filled or empty. There did not seem to be too much difficulty in persuading them to follow the diet since Mr. Vernon had seen how it relieved his pain before. The dietitian told them that if they had any dietary problems when they got home they could phone her and she would be glad to answer their questions.

Twenty-five days after admission, Mr. Vernon was discharged. His ulcer had apparently healed, his hemoglobin was 72 per cent and he was feeling much stronger.

PHLEBITIS

MARIETTE BREAULT

Age is no respecter of persons as this study of an 89-year-old patient reveals.

General Review

Simple phlebitis, or inflammation of the walls of the veins, occurs following injuries such as a perforating wound or a bruise; as an extension of an infection of the tissues surrounding the vessel; as a result of continuous pressure against the vein by a tumor or aneurysm and as a common complication of varicose veins. It is apt to arise in circumstances that promote stasis in leg veins. It is not an uncommon complication of late pregnancy. It should be anticipated in all patients who must be in bed for a prolonged period. For any bedridden patient, whether postoperative, postpartum or ill with a condition that significantly reduces muscular movement, provision must be made for adequate venous drainage from the lower extremities either by passive leg exercises or by postural changes and simple massage. A thrombus is likely to form at an infected point. Thrombosis, not due to infection, often is the reason for the development of secondary phlebitis where previously there had been none.

Thrombophlebitis is the term applied to the condition in which there is clot formation in a vein. The danger in this situation is that the clot, or a portion of it, may become detached and be swept into pulmonary circulation, producing embolism. The most common sites of thrombophlebitis are in the leg and pubic veins. There may be few or no symptoms referable to the local condition. The first intimation of the presence may be unexplained fever or pulmonary embolism. Thrombophlebitis involving the leg veins, however, ordinarily causes some pain and tenderness in the thigh or the lower leg and a certain degree of swelling of the limb. Treatment consists of complete bed rest with elevation of the affected limb. If there has been any evidence of pulmonary embolism, both femoral veins may be ligated to prevent further escape of clots that might give rise to a fatal embolism.

Anticoagulant therapy is used almost routinely. The administration of both Heparin and Dicoumarol is started at the earliest possible moment after the thrombotic process has been discovered. These preparations are given with the object of delaying blood clotting as a preventive measure in postoperative patients and to forestall extension of a thrombus once it has formed.

The condition demands much patience. It usually takes a long time for the patient to recover and regardless of what the nurse may do, the patient may still be uncomfortable.

Observation of Symptoms

One of the main dangers in thrombophlebitis is the possible occurrence of pulmonary embolism. It is important to observe the patient closely for sudden severe chest pain and possible collapse, with fever and expectoration of blood-tinged sputum.

Since phlebothrombosis may proceed unsuspected except for slight pain on movement of the feet, it is very important to be alert to the significance of such minor complaints. Early detection may prevent needless suffering as the result of an embolism.

Posture, Rest and Activity

Any pressure on the affected limb may cause pain. The patient moves reluctantly. It is difficult to use a bedpan because of pain on movement. The position of the affected limb and the amount of exercise to be allowed are dependent on the doctor's orders. Usually the legs are slightly elevated on a pillow. A cradle is placed over them to eliminate the weight of the bed linen. If the patient is in a Gatch bed, flexion must be avoided as much as possible at the angle of the hip to prevent stagnation of venous flow and danger of thrombosis. If the patient is on complete bed rest, she should be encouraged to breathe deeply four or

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Miss Breault, a junior student at Edmonton General Hospital, was awarded second prize for this study in the Macmillan Award Competition for 1960.

five times every hour so as to ensure deep inspiratory excursion of air. This helps to prevent hypostatic pneumonia or circulatory stasis in the lungs.

Under no circumstances should the nurse rub the affected area. It should be handled with utmost care when making the bed or giving a bath. Since recovery is tedious, good nursing care is very essential to the patient's comfort and well-being.

The patient is often depressed and discouraged. The nurse must make every effort to keep him content and have him realize the value of immobilization even though the convalescent period is prolonged.

The Patient

A great-grandmother, 89 years of age, in amazingly good health and spirits, Mrs. Langlois and her husband lived in a small resort town in Alberta. A married son, an only child, had his home nearby.

Mr. Langlois had had treatment for mouth cancer and was also partially blind. However, the elderly couple managed quite happily. Mr. Langlois had a small business in boat rentals and his wife enjoyed entertaining her family and friends or working at her embroidery and crocheting.

Mrs. Langlois had had many childhood diseases as well as typhoid fever but there was no history of diabetes, cancer or tuberculosis in her family. About one month prior to this admission she was treated in another hospital for pain in her chest and abdomen. A few days after her discharge she noticed, much to her dismay, that her ankles were swelling at night. The extent of the swelling increased rapidly, mainly on the right side, and finally affected her thighs and lower abdomen. She had serious discomfort in her legs for two weeks during which she elevated them to decrease the swelling and tried to keep her feet warm.

Present Illness

Upon admission she was found to have a very slight elevation of temperature — 99° F — but all other vital signs were normal. Her right leg was very hard and edematous; the skin red, warm and tender on palpation. Mrs. Langlois said that her feet frequently felt cold (probably the result of poor circulation) and that she had some difficulty in breathing after straining. Her only other complaint was that of pain in the lower lumbar spine. This discomfort had become increasingly worse in the last five years. She experienced some pain on palpation of the lumbo-sacral spine. The femoral pulse was present but weak in both legs. She also told the doctor that she was not voiding as much urine as she usually did.

Laboratory Reports

Prothrombin Time: This is a blood test which indicates the ability of the blood to form intravascular clots.

Mrs. Langlois' prothrombin time was 60% of normal. The administration of anticoagulants was considered unnecessary.

Electrocardiogram: This test was carried out during her first day in hospital to determine if the edema in her legs and her difficulty in voiding could be due to heart disease. To relieve any apprehension or fear this examination was explained to her. Mrs. Langlois understood that wires would be held in place around her ankles and wrists so that a machine could record the regularity and frequency of her heart-beats. We assured her that she would not experience pain, vibration or any other unpleasant sensation.

Treatment and Medication

Mrs. Langlois' phlebitis was treated medically. Surgical treatment, involving a phlebotomy, was not necessary. The principal aims of the medical care prescribed and given were to avoid complications such as embolism, to prevent any infection, and to encourage healing in the affected area. Bed rest, elevation of the patient's legs and a diuretic with measured intake and output were the chief features of the treatment ordered by the doctor. She was permitted to have an analgesic when the pain in her legs became too uncomfortable.

Nursing Care

Mrs. Langlois adjusted very well to the hospital environment although a slight language barrier made it more difficult for her to communicate with

the other patients. She was always extremely interested in ward activities; she read a great deal and she thoroughly enjoyed the frequent visits from her family members and friends.

We were constantly amazed by her variety of interests. She enjoyed knitting, embroidering and crocheting. Fortunately, her eyesight was excellent so that she could indulge in these pastimes as much as she wished. She asked her son to bring in samples of her handiwork for her nurses to see and took considerable pride in the fact that a crocheted table cloth had been valued at $100. A deeply religious woman she found much comfort and support in her faith and seemed able to accept her illness more easily because of it.

Elevation of her edematous legs on pillows and use of a bed cradle gave her welcome relief. We made sure that the pillows and the bed linen under her were kept free from wrinkles and creases. Her poor circulation and the edema of the tissues made her susceptible to decubiti unless precautions such as these were taken. For the same reason, we changed her position regularly and frequently. Her heels did become somewhat irritated but massage with a healing ointment helped to control this.

In the care of the aged person, a high protein diet, rich in vitamins B and C, is required. Proper protein nutrition is necessary to build up natural resistance and protect against infections. The vitamins play an important part in carbohydrate metabolism. Mrs. Langlois had a wonderful appetite and enjoyed her food very much. Her only request was for brown bread because she did not care for white.

Appropriate exercise was especially important since, because of her age and condition, she was prone to hypostatic pneumonia and thrombus formation. Periodic change in position and deep breathing at regular intervals proved very helpful as preventive measures.

We paid particular attention to the care of Mrs. Langlois' feet, again with her impaired circulation in mind. The toenails on her left foot were very long, thick and curled back. Soaking her feet in warm oil softened the nails so that they could be cut properly, thus preventing a break in the skin from ingrowing nails and possible infection.

At her own request, we cut Mrs. Langlois' hair so that she could care for it herself. It was very fine, tangled easily and, when long, was hard to keep tidy.

Skin care was a particularly important factor in this patient's care. Her age, her poor circulation and the edema of her legs and thighs made her very susceptible to bedsores. A daily cleansing bath, massage of her back, buttocks and heels and frequent change in position prevented this complication. The morning bath provided an excellent opportunity to chat with Mrs. Langlois and to observe her general condition. We checked on how well she was sleeping; the amount of pain she experienced; and the frequency of voiding. The patient found that during her first few days of hospitalization, voiding was very frequent. However, she understood that this was the effect of the drug that she was receiving. Gradually, the edema in her legs subsided until only the right leg remained slightly swollen and inflamed.

Another possible complication of enforced bed rest — constipation, was avoided because Mrs. Langlois ate well and properly, and drank adequate fluids. Her family kept her supplied with fresh fruit which was very helpful for this purpose and her nurses saw to it that fruit juices of her choice were supplied in mid-morning and afternoon.

Two weeks after her admission the doctor permitted Mrs. Langlois to sit in a chair with her legs elevated. She had great confidence in her doctor and looked forward to his daily visit. She walked about the ward for short periods each day without any particular difficulty except for a slight unsteadiness. Due to the latter, we made sure that someone accompanied her.

Plans for her discharge included a visit with friends in the city for a few days before she returned home. Her household duties would require arranging so that she could rest as she felt the need for it.

Health Teaching

The morning bath gave an excellent opportunity for teaching. Rest, exercise and general hygiene were stressed. Suggestions about her care in relation to her specific condition were discussed. We warned against crossing her knees which would tend to promote blood stasis. We emphasized the importance of elevating her legs whenever possible. It was suggested that she could use a footboard in her own bed and improvise a bed cradle to give her additional comfort.

Since her feet frequently felt cold, it was suggested that she should wear warm well-fitting socks and take warm foot-baths each day. The additional warmth would tend to improve general circulation. We showed Mrs. Langlois the proper method of cutting her toenails and suggested that a tiny roll of absorbent cotton should be placed beneath nails that tended to grow inwards. The cotton roll was to be changed each day. We advised her to pay special attention to the fit of both her stockings and her shoes.

Posture is important and the patient should sleep on a firm mattress. A soft mattress may allow enough flexion of the trunk at the hips to impede circulation to the lower extremities. Because she was very short, Mrs. Langlois was told that she should always use a foot stool on which to rest her feet if a chair was too high for her in order to prevent stasis of blood in the lower extremities. She was to avoid wearing anything that constricted circulation, such as rolled garters or a girdle.

Obesity in the patient with venous disease increases congestion and probably lessens the effectiveness of muscles in assisting with the return flow of blood. If the patient has limited cardiac capacity in addition to vascular disease, the heart and the entire vascular system are taxed to an extent that distribution of blood to the extremities is curtailed. Reducing diets, however, must always be under the direction of the physician. Mrs. Langlois, who was only four feet ten inches in height, weighed 130 pounds. Part of this weight was due to the extensive edema and with improved diuresis, her weight was somewhat reduced. She was still overweight for her height but no diet was suggested for her, again in view of her age.

SUMMER SAFETY

Consumer Reports offers some sensible safety measures for users of rotary mowers as follows:

Before Starting

Read and digest all the manufacturer's instructions.

Check your mower for cracks, loose nuts or bolts, etc., in the blade, blade mounting, and elsewhere; tighten loose bolts and replace defective parts immediately.

Don't mow a wet lawn — you may slip and lose at least a toe.

Rake the lawn before mowing to get rid of loose objects.

Be sure the fuel tank is full before starting.

When Starting and Operating

Permit only mature persons (never children), who understand the machine, to start or operate it.

Stand clear of the discharge opening.

When using a wind-up impulse-type starter, always be careful where you place your feet and never delay starting the engine after winding the spring of the starter.

When mowing, keep a firm hold on the handle; watch your footing; never run; wear stout shoes; don't allow the discharge opening to point at anyone while the blade is turning.

Mow across slopes so you can control your machine.

If you run out of fuel, allow the engine and muffler to cool before refuelling.

If the mower begins to shake more than usual, stop the engine and check the blades and mounting for loose bolts.

When Cleaning, Maintaining, or Repairing

Remove the spark plug before touching the blade. Turning it can start the engine.

Don't tamper with the governor — increasing the engine speed may put more stress on the machine than it will bear.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

CNA Convention, 1962

Most members agree that conventions are important to them and for this reason they attend regularly. The importance of conventions to the Association is another point to consider. Biennial meetings are vital to the Canadian Nurses' Association. They are the group activity in which all members have the opportunity to participate.

The convention is the yard-stick and direction finder that keeps the Association on course. It enables the officers to learn from members and each other about new ideas and improvements. No organization survives if its leaders function in a vacuum. They must keep in touch with the members by whose consent they manage the affairs of the Association. All members have a right to be heard. The convention is the means by which they can exercise their franchise, formally and informally. Much of the business of nursing takes root at the convention. There are constant, unscheduled, informal conferences and consultations. Having all of the people concerned available at the same place facilitates planning and decision-making. An informal chat at coffee, at lunch, or in the corridor saves reams of correspondence. The convention brings new talent to the fore. It provides an opportunity for the Nominating Committee and officers to recognize potential chairmen and committee members. Could anything be more important to the Association and to you?

A convention is really the Association on stage, with every member in the audience, watching it perform. The members can judge its strengths and weaknesses, recognize its accomplishments and evaluate its ability to serve them in the future. As with all performances, being there is far better than reading about it, after the event is over.

Plan now to attend the next Biennial Meeting in Vancouver in June, 1962.

RNAO Meeting

More than 1700 registered nurses attended the three-day annual meeting of the Registered Nurses' Association of Ontario. Miss ELLA M. HOWARD of Toronto, recalled the 35-year history of the association in her presidential address.

Miss FLORENCE H. WALKER, retiring as executive secretary of the RNAO after 16 years, was honored at a dinner given by the association.

It was announced that the sum of $30,000 will be added to the permanent education loan fund to assist graduate nurses with the costs of university education. Through this fund a nurse may borrow up to $1,000 interest-free for three years from the completion of her course. The association is also budgeting $2,400 to assist students in training.

The proposed College of Nurses was discussed under the direction of Miss HELEN MCARTHUR of Toronto who was chairman of the committee that carried out the investigation of this issue.

Two speakers, Miss DOROTHY ROWLES, inspector, nursing branch, Department of Health, and Miss MOYRA ALLEN, associate professor of nursing, McGill University, spoke on the subject of whether nursing education is adequate to deal with the health problems of Ontario.

International Visitors

Canadian nurses were happy to welcome to Canada 25 distinguished nurse visitors from Great Britain and Northern Ireland, enroute to and from the ICN Congress in Australia.

A number of specific programs were planned in different areas of Canada according to the special interests of the nurses, while others observed briefly in one or two areas and enjoyed the scenic beauty as they travelled across Canada.

Although our capital city is off the main route, many found it possible to include Ottawa in their tour. We were happy to receive these visitors at National Office: Miss M. F. CARPENTER, director, education division, Royal College of Nursing, England; Miss KATHERINE HALL, general secretary, Royal College of Nursing, England; Miss JOAN GRAY, general superintendent, Queen's Institute District Nursing, England; Miss KATHLEEN FOWLER, sister tutor, Middlesex Hospital, England; Miss A. T. ALTSCHUL, principal sister tutor, Maudsley Hospital, England; Miss MABEL WILSON, registrar, General Nursing Council, Scotland; Miss M. F. BOWMAN, sister tutor, Lucester Royal Infirmary, England.

During the last two months, National Office has also had the privilege of receiving and initiating program arrangements for Miss SOMWONGSE MOWLANONDA, director of nursing at Vajira Hospital, Thailand, who is a Colombo Plan student. Eight nurses who are matrons, deputy matrons and tutors from Great Britain and Northern Ireland spent some time with us.

May we again express the appreciation of the international nurse visitors, to the provincial associations and agencies for excellent arrangements for programs in all parts of Canada.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — JULY, 1921)

Excerpt from the address of the president, Miss Edith MacPherson Dickson, to the national meeting of nurses, in 1921.

"The object of this association shall be to encourage mutual understanding and unity among associations of trained nurses in Canada." It is plainly, then, not the duty of this association to direct the activities of its members. Indeed, if this were an object of the association, it would be impossible of fulfilment; for, while there is a B.N.A. Act, the policies of our national organization must of necessity be as limited in scope as that of our Federal Government. We need not regret our limitations, for there yet remains much for us to do as a unifying force in the nursing world. The second object is "To acquire a knowledge of the methods of nursing in every country." And the third object reads: "To elevate the standard of professional education."

There was a time when the profession stood for higher scientific knowledge and general culture than was to be found among the trades, and, in consequence, members of the profession justly claimed a higher place in society than that occupied by others. Today one may well ask the question: Have we of the profession become too materialistic and have we lost appreciation of the value of culture, or is it that the trades have developed such a high standard of education and culture, which makes for scientific efficiency, that these two classes occupy positions in society so nearly parallel? In this connection one may well enquire in what respect, in regard to general culture and standing in the community, does the average chef not compare favorably with the average dietitian, the average contractor with the average architect, the average skilled machinist with the average physician, and the average dress-maker or milliner with the average graduate nurse?

It is the breadth of training, improvement, and refinement of mind, morals and taste that is to keep the profession even on a par with other vocations of life.

How sickness enlarges the dimensions of a man's self to himself. — CHARLES LAMB

NURSING PROFILES

Canadian nurses have a proud record of service with the World Health Organization. Today, many of them are sharing their experience and knowledge with colleagues in widely scattered areas. Their aim — to help others to help themselves. **Willa Josephine Routledge** joined WHO and the Colombo Plan in 1955. Her first appointment took her to Hyderabad, India, where she worked for a two-year period. In 1957, she was assigned to the Higher Institute of Nursing, University of Alexandria, Egypt. Late in 1960 she was appointed senior adviser with the WHO project in Iran with headquarters in Teheran.

WILLA ROUTLEDGE

Miss Routledge began her nursing career in Saskatchewan as a graduate of Saskatoon City Hospital. During 1944-48 she served as supervisor in SCH with one year's leave of absence to obtain her diploma in teaching and supervision from the University of British Columbia. In 1948 she joined the staff of the Royal Jubilee Hospital, Victoria as clinical supervisor, where she remained until 1950. For the next four years she worked in Vancouver, first as instructor, then as senior instructor with the Division of Tuberculosis Control and finally as a part time staff member and student of the School of Nursing, U.B.C. while she completed requirements for her B.Sc.N.

When she graduated from Saskatoon City Hospital, Miss Routledge was awarded a gold medal for devotion to duty. This award is as richly deserved now as it was then. Her sincere interest in her profession and her whole-hearted competent efforts in carrying out its aims often under very trying circumstances have always impressed her friends and colleagues. A lively sense of humor, and a genuine liking for people are assets that have won friends for her wherever she has gone.

Geneva Lewis was recently appointed director of public health nursing, Ottawa department of health. A graduate of Hamilton General Hospital, Mrs. Lewis obtained her bachelor of science degree in public health nursing from the University of Buffalo.

Her professional career has been devoted mainly to the public health field. In 1940 she joined the staff of the Colbeck Clinic, Welland, Ont. where she worked for the following five years. In 1950 she was appointed a staff nurse with the Welland and District Health Unit. Later, she became supervisor of the same unit and remained there until 1960. Mrs. Lewis was president of district No. 4, RNAO, 1958-60 and secretary-treasurer of the public health area conference No. 3, 1956-60.

(Nakash, Montreal)

MARIE DESBARRES

In 1939, **Marie Letitia DesBarres** crossed our southern boundary line to become administrator of The Alfred I. Dupont Institute, Wilmington, Delaware. In December, 1960 after 21 years of service, Miss DesBarres retired.

Since her graduation from The Montreal General Hospital, she has had a busy professional life. The first three years, spent as a staff nurse in the MGH operating room, were followed by a similar period as supervisor of the operating room, Lewistown Hospital, Pennsylvania. Miss DesBarres returned to Canada to become assistant administrator, Shriners' Hospital for Crippled Children, Montreal in 1930 — a position that she filled for the next nine years before returning to the United States once more. She has held membership in an impressive list of professional organizations including the American College of Hospital Administrators, American Hospital Association, the National League for Nursing and the American Nurses' Association. She is a member of the alumnae association of the School for Graduate Nurses, McGill University from which she obtained her certificate in hospital administration.

The busy years have left little time for her to develop leisure-time activities. Now, however, she is looking forward to playing golf, gardening and catching up on her reading. A Nova Scotian, her address for the present is Guysborough.

Lilija Treimanis, a graduate of Toronto General Hospital, has been awarded the Lewis Miller Wood Memorial Award in ophthalmic nursing. The award has been established by the Canadian National Institue for the Blind in memory of their former president and will be awarded annually to an undergraduate or graduate nurse of T.G.H. Mrs. Treimanis was the first recipient and is now entitled to a period of study in one of the larger ophthalmic centres.

CHALLENGE TO FREEDOM

If there is one thing that history has taught us — or should have taught us — it is that change is inevitable. No nation stands still. And the faster the pace of life and the greater the developments in the field of communications the less the possibility of a country avoiding the main stream of history and moving faster and faster with the winds and tides of international events. Our one hope is that we can, as a people, keep control of our craft and steer a safe way into the future.

The implications of what is taking place in this fast-moving twentieth century present a very real and a very immediate danger. Too many people are too inclined to say in the face of what is going on that "problems are too big for me to cope with, so I'll leave it to someone else who knows something about them." The attitude here is that the individual can and should wash his hands of the whole business and leave everything to the so-called experts. Nothing could present a greater threat to our way of life. Nothing could be more swiftly and surely destructive of freedom than a willingness to surrender individual responsibility to whoever is prepared to accept it.

Freedom can as surely be lost by an unwillingness to assume the burdens which it imposes as it is by the imposition of superior strength. The formation of communes in China, which is one of the great historical examples of regimentation, imposes on the individual a form of serfdom or slavery which in the free world an individual imposes upon himself when he refuses to think or act with the independence which our free way of life offers.

Never, never, never underestimate the power of the individual. If we do, then we are denying the very essence of the form of democracy under which we live. Freedom must be exercised if it is to mean anything or be worth anything. Freedom may be impaired or lost by encroachments and attacks from without but also, and this must never be forgotten, it may be destroyed by lethargy or ignorance from within.

One of the great dangers in underestimating the worth of the individual is that we are inclined to shrug off onto the shoulders of government the problems which beset us. It is sometimes forgotten that the power of government stems from the individual. That we, as individuals, beget the kind of government we demand and insist upon. That if we are lax, weak, unwilling to assume our responsibilities, then we will find that we will have governing us those who are only too willing to assume the power which we have forgotten we possess.

— *News Letter,* Canadian Chamber of Commerce.

CHOLELITHIASIS AND HIATUS HERNIA

ANNE DRISCOLL

An understanding of the principles that underlie therapeutic techniques, ensures intelligent nursing care and contributes to an uncomplicated recovery for the surgical patient.

Introduction to the Patient

BRIEFLY, I scanned the statistics on the admission sheet. From the information, I attempted to sketch a mental picture of the patient who was about to become a guest of our surgical ward. A gallbladder ailment immediately produced a mental image of the typical "fair, fat and forty" female. A glance down the corridor exploded the theory as the lady who was approaching the desk, accompanied by the admitting clerk, was of average weight, medium stature and had *dark* hair! Her complexion was sallow, although there was no evidence of jaundice. She appeared to be completely exhausted, but assured me that she was in no immediate discomfort.

Following the usual formalities, I showed Mrs. Foster to a semi-private room and introduced her to her neighbor, who had been anxious to have someone to chat with. After recording the routine data and finding out the nature of Mrs. Foster's symptoms, I left them alone to become better acquainted.

After Further Acquaintance

Mrs. Foster was an amiable, pleasant, quiet-spoken woman of 55. From all outward indications, she did not appear to be unduly disturbed about her impending operation. It was not until after her surgery that I discovered that she was a true stoic. During the course of her first postoperative walk down the corridor she confessed that she had had a strong conviction she would not survive the operation.

Married 25 years ago, her interests have revolved largely around her home life. Her only child, a son, was married three days prior to her hospitalization. Though she had high praise for her new daughter-in-law, there was now a void in her life that needed to be filled.

Mrs. Foster was an intelligent, well-read person, and certainly well-versed in medical terminology. She had been employed as a medical secretary in a doctor's office for 15 years. During that time, she became very skeptical about the reality of the laments of the female patients and made a silent pledge that she would never join the ranks of those who appeared to be "enjoying" ill health. Consequently, it was the better part of a year before Mrs. Foster admitted even to herself, that something was wrong. After a three-month dietary regime, consisting almost solely of eggs — the only food that left her relatively free of digestive distress — Mrs. Foster decided to return to the familiar surroundings of the doctor's office as a patient. From the doctor's findings, together with the information she was able to provide, he arrived at a tentative diagnosis of cholelithiasis and hiatus hernia. The presence of a gastric or duodenal ulcer was considered as a possibility.

Cholelithiasis

The liver, which is the largest gland in the body, is a vital organ in metabolism. Blood from nearly all the abdominal organs, passes through its capillaries before reaching the general circulation. Many chemical reactions occur within its cells in preparing the various foodstuffs, absorbed from the intestine, for use by the body. The liver produces daily approximately 1,000-1,800 cc. of bile, a greenish-colored fluid that is carried to the duodenum by the

When this study was prepared, Miss Driscoll was a first-year student at St. Paul's Hospital School of Nursing in Vancouver, B.C. Her study received Honorable Mention in the 1960 Macmillan Award Competition.

bile ducts. This system of ducts has, extending from it, a small pear-shaped sac called the gallbladder which is located beneath the liver. The gallbladder, with a capacity of approximately 50 cc., serves as a reservoir for bile and concentrates a large portion of it.

Two ducts emerge from the undersurface of the liver, and immediately join to form the hepatic duct. It merges with the cystic duct from the gallbladder, to form the common bile duct which opens into the duodenum. Since bile plays such a major role in digestion and fat metabolism, anything that obstructs its flow seriously impairs digestive processes. Obstructions occur as the result of stone formation, known as cholelithiasis if the stones are located in the gallbladder, or choledocholithiasis if they are located in the cystic, hepatic or common duct.

Previous infection or the precipitation of bile constituents — bile salts and cholesterol — may give rise to stone formation. The number of stones varies from one, usually of pure cholesterol type and about the size of a large grape, to a multitude of small stones of diverse shapes. There may be no manifestation of cholelithiasis until a stone becomes lodged in the biliary duct system, although the patient often gives a history of indigestion after consuming rich, fatty foods and of occasional discomfort in the right, upper quadrant of the abdomen. Gaseous eructations occur almost immediately following meals, in contrast to those associated with gastric ulcer, which occur several hours after a meal.

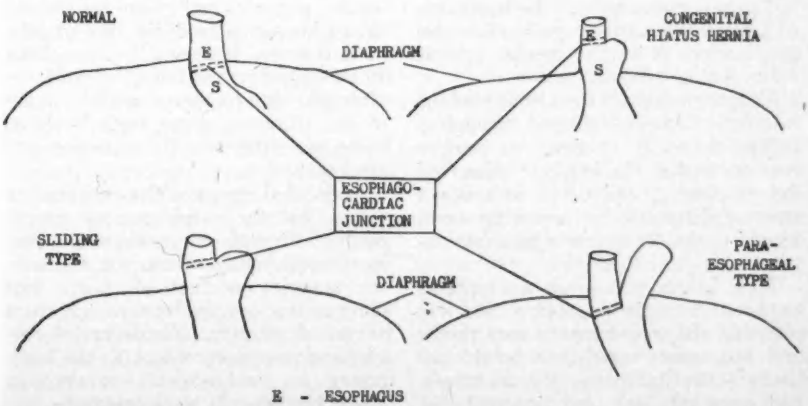
Obstruction of bile passages by a stone is characterized by severe pain under the right costal margin, radiating to the back and followed by nausea and vomiting. Biliary colic, as this pain is called, is frequently of sudden onset and is probably due to spasm of the ducts as they attempt to dislodge the stone. Chills, profuse diaphoresis and tachycardia are also significant symptoms. Such an attack may occasionally terminate in complete prostration.

Stones lying in the gallbladder and cystic duct do not cause an obstruction of the flow of bile from the liver into the duodenum. Stones that lodge in the common duct or the Ampulla of Vater obstruct the flow of bile which results in absorption of bile pigment and produces jaundice.

Hiatus Hernia

Hiatus means opening or foramen. The term hiatus hernia refers to a protrusion or herniation of the distal end of the esophagus and the cardiac end of the stomach through a weakness in the diaphragmatic hiatus — the point at which the esophagus passes through the diaphragm.

There are three different types of hiatus hernia — congenital, para-esophageal and the sliding type. In the latter, which Mrs. Foster had, the esophago-gastric junction and the proximal end of the gastric cardia protrude through the peritoneal reflections and pass through the diaphragmatic hiatus into the mediastinum or either pleural space.



Sometimes a hiatus hernia produces no apparent symptoms but is discovered inadvertently when an x-ray is taken for another reason. On the other hand, symptoms may be severe. They may simulate gallbladder syndrome, or those of peptic ulcer. Occasionally, there is respiratory embarrassment due to pressure on the lungs and palpitation due to interference with heart action.

Signs and Symptoms

About 10 months previously, Mrs. Foster had experienced tightness and pain across her chest and upper abdomen. This was followed by persistent dyspepsia after meals, accompanied by dull, crampy, epigastric pain. For the past three months, she had been troubled almost constantly with gas and distention, obtaining only occasional relief from carbonated beverages. She had a definite intolerance for fatty foods, spices, onions and cabbage. She could take tea, coffee and eggs in liberal quantities without ill effects. Mrs. Foster found that she slept more comfortably in a semi-sitting position.

The patient's history of past illnesses included an appendectomy, at the age of 22, and typhoid fever at 46, from which she claimed she made a satisfactory recovery.

Diagnostic Procedures and Associated Nursing Care

To confirm the admitting diagnosis, an esophagoscopy was scheduled for 8:00 A.M. the day after admission. This required a small amount of physical preparation and was the beginning of a more extensive program of mental preparation. A healthy mental attitude paves the road to recovery.

Esophagoscopy is the viewing of the interior of the esophagus through a lighted tube. It is done to remove foreign bodies, to inspect lesions of the esophagus, and often to make a positive diagnosis by removing small bits of tissue for microscopic examination.

Mrs. Foster was given a simplified explanation of the procedure. She was told that she would have a sore throat and hoarseness which she would not likely notice until after the anesthesia had worn off. She was also told that she would be receiving visits from the anesthesist and the interne to obtain some additional information.

Although an anesthetic was to be given, a suppository rather than an enema was considered sufficient to empty the colon. After an early evening bath, Mrs. Foster was settled for the night in a semi-Fowler's position, Seconal was given to ensure a sound sleep. Just before her sedation, it was pointed out that she would be required to fast from midnight and that she would be undisturbed until the night nurse awakened her for a urine specimen and to give the necessary medications at 7:00 A.M.

Demerol 75 mg. and Hyoscine gr. 1/150 were given before the anesthetic to allay excitement and decrease oral and nasal secretions, thus facilitating the anesthetic induction and lessening the possibility of aspiration while the patient was unconscious.

When Mrs. Foster returned from the examination she was conscious and very pale. Since it is equally important to be on the alert for signs of shock after a relatively simple procedure as it is after major surgery, her blood pressure, pulse and respirations were noted q.15 minutes. A blood pressure of 130/65 was maintained for four consecutive readings and her pulse and respirations were considered within normal limits at 84 and 22 respectively.

After an esophagoscopy it is necessary to test for the return of the gag reflex before liquids or food are given. This can be done by gently tickling the back of the throat with a cotton swab or tongue depressor. A normal saline gargle was given to relieve throat irritation and Sucrets to alleviate dryness. By late afternoon, Mrs. Foster appeared to have regained her strength. Her roommate and the ladies in the adjoining room were lively so there was little time for reflection and anxiety.

A detailed report of the examination stated that the esophagoscope passed readily through a patulous, cardio-esophageal junction into the stomach, the superior portion of which was lying well above the level of the crura of the diaphragm. Tissue and secretion specimens were sent to the laboratory for pathological examination. No malignant cells were detected.

That evening, the doctor visited

Mrs. Foster to inform her of the results of the examination and to advise her that she would have her operation in three days. The following two days were tense and strained, although Mrs. Foster did her utmost to conceal her concern.

Preoperative Care

It was particularly important that Mrs. Foster should be instructed adequately in proper breathing since her hernial repair would make her abdomen very tender. The natural reaction would be to take short, shallow respirations which predispose to atelectasis and other pulmonary complications. The physiotherapist was called to teach proper postoperative breathing and coughing. Thorough cleansing of the skin helps to reduce the incidence of wound infections. The area from the nipple line to the pubic region was cleansed twice daily with Phisohex, an antiseptic preparation that reduces the number of pathogenic bacteria on the skin surface. It has a cumulative effect. The evening preceding operation, a complete skin preparation, which included shaving the operative area, was performed.

A soapsuds enema was given in order to cleanse the colon as completely as possible. Since the patient would not have another bowel movement until after the return of normal peristalsis, a good elimination was necessary to avoid the accumulation of feces in the colon. Mrs. Foster was a scrupulously clean person and did not have to be encouraged to practise good oral hygiene. This measure is important to lessen the possibility of parotitis and infections of the upper respiratory tract that predispose to more serious respiratory complications.

Since Mrs. Foster was somewhat reticent regarding her religious beliefs, the matter was not pursued. She received a good deal of encouragement and fortitude from her family, her new-found friends, the medical staff and nurses.

The evening before surgery, she was informed about the proceedings of the following day. It was pointed out that she would have gastric suction to prevent nausea and vomiting and, possibly, blood and intravenous solutions to hasten her recovery. She was also advised that a routine similar to that which preceded the esophagoscopy would be followed, including fasting after midnight, a urine specimen in the morning, and preoperative medications.

She was settled in her usual semi-Fowler's position by 9:30 P.M. and was given sedation of Tuinal. Despite her apprehension, she went to sleep quickly and slept soundly during the entire night.

Just before going to the operating room, Mrs. Foster was requested to void — a prophylactic measure to prevent the possibility of injury to a distended bladder during surgery or accidental micturition while under anesthetic, either of which could lead to infection. Demerol 100 mg. and Scopolamine gr. 1/150 were given to allay excitement and to lessen nasal and oral secretions.

Postoperative Nursing Care

Since our objective is to restore the patient to health without the development of complications, anticipation and prevention form the basis of good postoperative nursing care. Immediate postoperative care had been carried out in the post-anesthetic room where a close check had been kept for any indication of shock or hemorrhage.

When Mrs. Foster returned to her room she was conscious and slightly cyanosed. Her first blood pressure reading was 136/74, dropping at each successive 15-minute reading to 120/80, 110/75 and finally to 80/40. The foot of the bed was immediately elevated and a light blanket added for warmth. Her pulse maintained a strong regular pace of 68 to 72. There were no indications of air hunger or undue restlessness, which made the possibility of hemorrhage unlikely.

In the meantime, the gastric suction was connected and the tubing checked for kinks. The dressing was checked to ensure that it was not restricting proper breathing and that there was no saguinous drainage around its outer edges.

Mrs. Foster's blood pressure rose to 130/80 and remained stable after the removal of the shock pins. She was placed in a low Fowler's position on her operative side, to allow more freedom in breathing. Her position was

changed at least every two hours since lack of movement can rapidly lead to hypostatic congestion, atelectasis, pulmonary embolism, phlebitis or other serious complications. The doctor had ordered Demerol 100 mg. to be given q. 4 h. to subdue pain and restlessness. This facilitated deep breathing and coughing, which, as a result of her preoperative preparations, Mrs. Foster carried out willingly and well when she was reminded to do so.

Additional prophylactic measures included a warm bath following her return from surgery, a back rub each time she was turned and orange slices to suck to stimulate the flow of saliva and keep her mouth moist and fresh. Special mouth care was given frequently, using hydrogen peroxide to cleanse her mouth and a mixture of lemon juice and liquid petrolatum to refresh it.

Mrs. Foster dangled her legs the evening of her surgery. This was done shortly after the administration of Demerol to make the change of position less painful. She was most cooperative since she realized the value of early ambulation in promoting a speedy, uncomplicated recovery. Sitting up also helps to overcome urinary retention. Mrs. Foster voided 500 cc. the evening of her operation.

The gastric suction was irrigated p.r.n. and at least q. 4 h. to ensure proper drainage. It was clamped one hour and open one-half hour alternately on her first postoperative day. Since there were no ill effects, the next day the lengths of time were increased to two hours and one hour respectively. The suction was removed the following day.

Intravenous therapy was prescribed to prevent dehydration and replace electrolyte loss. It also relieved her thirst. To improve the patient's general condition and promote rapid healing, 2 cc. of B-plex and 500 mg. of vitamin C were added to each bottle of solution. B-plex is also valuable in preventing or overcoming anemia. Mrs. Foster's hemoglobin ranged from 10 to 11 gm. per cent, the normal being 12 to 16, so she had a mild anemia. Vitamin C is not stored to any appreciable extent, and a deficiency may cause delay in the healing of a wound or a breakdown in the healing process.

An accurate record of intake and output was kept for the first three postoperative days to enable the doctor to determine the patient's nutritional needs and the over-all picture of fluid and electrolyte loss. This included fluid suctioned from the intestinal tract, diaphoresis, wound drainage and voiding. Nothing was given by mouth until noon of the first postoperative day, when one ounce of clear fluids q. 1 h. was permitted. Since extremes of temperature may give rise to distention, tepid and warm fluids were given.

Despite the precautions taken, Mrs. Foster was not free from abdominal distention. She was given a suppository, and was allowed a rectal tube p.r.n. These measures helped her to pass flatus and made her more comfortable, until she was given her first postoperative enema five days after surgery.

Intravenous therapy was discontinued on the fourth postoperative day. The patient's diet was supplemented with Factrin t.i.d. This medication is composed of iron and a full complement of hematopoietic factors which are of value in the treatment of anemia. The order for diet read "light, to as tolerated," and by the fifth postoperative day she had progressed to roast beef, complete with potatoes and gravy! Mrs. Foster amazed everyone with her activity. She was up, with assistance, on her first and second postoperative days taking short walks, which helped her to regain strength, confidence and a good appetite. By the fifth day, she was able to walk and sit in a chair comfortably, and went to the TV room where she enjoyed a few of her favorite programs.

Reducing narcotic consumption postoperatively is sometimes a problem for the nurse. As mentioned, Demerol, 100 mgm., was given as an analgesic postoperatively and sodium luminal gr. 3 was given at h.s. The latter hypnotic was chosen since it is long-acting and can be administered parenterally, which is a necessary factor when the patient is receiving nothing by mouth. The amount of Demerol was reduced as Mrs. Foster's pain lessened. Her final dose was given at midnight on her second postoperative day. Thereafter aspirin phenacetin

compound with codeine gr. ½ relieved pain. Phenobarbital gr. 1½ was substituted as a hynotic at bedtime.

The surgeon had inserted a Penrose drain — a soft, flat rubber drain not unlike the finger of a rubber glove but open at either end — into the incision to permit drainage. A large safety pin had been fastened to the exterior end to prevent it from slipping back into the abdominal cavity. This drain was shortened an inch or two every day, and care was taken not to dislodge it. Frequent reinforcement of the dressing may sometimes be necessary to prevent contamination of the wound. The skin sutures were removed on the eighth day and the retention sutures and drain on the following day.

By the time Mrs. Foster's hemoglobin was 11.9 gm. per cent her cholesterol level was 239 mg. per cent, which is within the normal limits of 150-270 mg. per cent.

The estimation of the cholesterol level is valuable to the doctor in determining the prognosis since a high level is significant in gallstone formation. Cholesterol is excreted from the body by way of the bile. When the mechanism for disposing of it is inadequate, cholesterol may appear in gallstones. Cholesterol stones are known as metabolic stones, and occur when there is an abnormally high concentration of cholesterol in proportion to bile salts, as in diabetes mellitus, pregnancy and obesity. It is interesting to note that typhoid fever predisposes to gallstones as an increase blood cholesterol accompanies this disease.

An upper gastrointestinal series was performed to ascertain the degree of healing of the hernial repair. The results were satisfactory and the doctor left orders for Mrs. Foster to be discharged on her 10th postoperative day.

Mrs. Foster was most anxious to know if there were any dietary precautions she should take. She was told that her digestive system could function satisfactorily without the gallbladder and that a well-balanced, nutritious diet would help to keep her at the peak of good health. It was suggested tactfully that she should arrange to have a periodic medical check-up.

Mrs. Foster told us that she had a new lease on life and that she could not remember when she felt so well and, furthermore, she intended to stay that way!

In Memoriam

Millicet Barnes, a 1923 graduate of Lady Stanley Institute, Ottawa died on April 24, 1961. She had been on the staff of the Royal Ottawa Sanatorium for many years and was the assistant director of nursing.

* * *

Suzanne Crowley who graduated from St. Michael's Hospital, Toronto in 1910, died suddenly on April 17, 1961. She had engaged in private nursing in Peterborough, Ont. for over 40 years.

* * *

Mildred (Clear) Enright who graduated from Royal Victoria Hospital, Montreal in 1923 died suddenly on April 13, 1961. In 1936 she joined the staff of the St. Elizabeth Visiting Nurses' Association, Toronto as one of their first public health nurses. Later she assumed responsibility for nursing education with the same organization.

Marion R. (Marsh) Evans, a 1912 graduate of Vancouver General Hospital, died on March 28, 1961.

* * *

Margaret (White) Ferguson who graduated from Stratford General Hospital, Ont. in 1942 died in September 1960 after a long illness.

* * *

Yolande Cesta Greco, a 1940 graduate of St. Mary's Hospital, Kitchener, Ont. died on January 26, 1961. During her professional career she served with the Victorian Order of Nurses in North Bay and Montreal.

* * *

Jean (Blyth) Low, a graduate of the Lady Stanley Institute, Ottawa in 1917 died suddenly in Clearwater, Florida on March 25, 1961.

(Continued on page 663)

Amyotrophic Lateral Sclerosis

MICHELINE BOIVIN

There is neither cure nor specific treatment for amyotrophic lateral sclerosis. Patience and understanding are key words in this description of nursing care given to a patient with a degenerative disease.

MRS. JONES' signs and symptoms on admission were urinary incontinence, hemiparesis, and increasing difficulty in talking. After numerous tests, a diagnosis of amyotrophic lateral sclerosis was made.

The Disease

Amyotrophic lateral sclerosis is a degenerative neurological disease of unknown etiology, which involves the anterior horns of the spinal cord and the Betz cells in the pre-Rolandic motor cortex. Chromatolysis can be seen in the swollen, rounded-out nerve cells whose nuclei have been pushed to the periphery where they degenerate. Frequently, excessive pigmentation is found in these cells. Degeneration also occurs in the nerve fibres of the gray matter of the cord, the anterior roots, and the muscles which are supplied by these nerves. Astrocytic proliferation forms a diffuse scarring in the involved nerve tissue. Similar changes occur in the motor nuclei in the medulla, in the Betz cells of the motor cortex. A secondary degeneration occurs in the pyramidal tract fibers.

Amyotrophic lateral sclerosis is a chronic, progressive disease; the prognosis is poor. There is a slight predominance in the male, with the usual age of onset being between 30 and 45 years. Progress of the disease is usually slow, although the life expectancy is seldom more than two years. Death may be precipitated and often results from pulmonary infection or choking.

Social History

Mrs. Jones was married, had no children living and acted as her husband's secretary. At the age of 47 she was a very active woman who enjoyed gymnastics and outdoor sports. Her social life was rather limited since her husband was 25 years older than she and had a serious speech difficulty that made him feel very self-conscious in public. In spite of these circumstances they were a very happy couple. They had no financial difficulties. Mr. Jones was a self-employed house painter, who was able to work steadily.

Medical History

About one month prior to her first admission, Mrs. Jones had a fall. She lost consciousness for a short period and had soreness on the right side of her body and left side of her neck for a few days. After her fall, she began to lose muscular strength on her right side and to have a little difficulty articulating. She noticed, too, that she was voiding frequently, about 10 to 15 times a day, and was sometimes unable to control her bladder. She had some impairment of hearing and sight, staggered slightly when walking, and had a prickling sensation in the right arm and leg. Before her fall, she had experienced difficulty in picking up objects and had dropped glassware — something she had never done before. Her relatives told her that she was "getting paralyzed" because of the change in her walk.

Clinical Investigation

The day after admission, a physical examination was done and her medical history taken. A neurological examination followed a few days later. The physical examination revealed a marked weight loss. The doctor was unable to visualize the fundi of Mrs. Jones' eyes properly. Fibrillation of the tongue and fasciculations (uncoordinated contractions) in the shoulder girdle, pelvic girdle and limbs were noticed. There was right facial weakness, with the soft palate moving to the left. There was no convincing

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Miss Boivin, was a first-year student at Jeffrey Hale's Hospital School of Nursing, Quebec City, when this study was prepared. It was awarded Honorable Mention in the 1960 Macmillan Award competition.

evidence of sensory or visual loss. The patient was euphoric and cooperative.

The neurological examination revealed some very rapid reflexes, absence of the Babinski reflex, a slight cutaneous abdominal reflex, and hyperactive tendon and facial reflexes. Superficial sensation seemed diminished on her right side. Mrs. Jones had a marked cerebellar dysarthria (stammering) accompanied by moderate trunk and limb ataxia and moderate to marked spasticity of all four limbs which was more pronounced on the right side.

Diagnostic Tests

Urine and blood tests and other diagnostic measures were performed in an attemp to establish a diagnosis. The results of a urinalysis, hemoglobin estimation, sedimentation rate, white blood cell count, differential WBC., lumbar puncture, and chest x-ray were within normal limits.

Visual field tests showed a peripheral constriction in the left eye on the temporal side with apparent enlargement of the blind spot. This deviation from normal was a consequence of motor neuron disease.

An electromyogram indicated upper neuron disease with marked reflex hyper-excitability and the type of fasciculations that are associated with it. Fasciculating movements could be induced by stretching small parts of the muscle; they appeared the same as the spontaneous movements.

A cystometrogram gave evidence of normal sensation, but revealed an uninhibited bladder contraction, an urgent initiation and a residual of 75 cc. These results are typical of a reflex, neurogenic bladder.

Anterior, posterior and lateral x-rays of the skull were taken. A fairly large calcification was located in the area of the pineal gland, but the gland did not appear to be displaced. The calcification is related to amyotrophic lateral sclerosis.

Nursing Care and Treatment

From the moment of admission, Mrs. Jones received special medical attention. After the diagnosis was made, all nursing care was of a palliative and prophylactic nature since there is neither cure nor specific treatment for this disease. At the beginning of her illness, Mrs. Jones was kept as independent as possible. She was encouraged to do as much as she could for herself. As the disease progressed, she needed more and more attention and eventually was unable to care for herself at all.

On the first day, we explained the hospital and ward routines to her. She was told that some tests would be done in the next few days. She was very cooperative, but rather euphoric. She was given a well-balanced diet and allowed to be up and around as desired. Every morning she had a tub bath and was assisted to wash and dress. She exercised by walking up and down the hall with the aid of a cane. She was fond of music and spent most of her time listening to the musical programs on the radio.

After the confirmation of the diagnosis, Mrs. Jones asked for some explanation about her condition. The doctor told her that the disease had originated in the spinal cord and that the signs and symptoms would disappear after a few weeks. She would have difficulty in walking for part of her life, but physiotherapy would help considerably. Although she was depressed she seemed to appreciate the explanation. Mr. Jones wanted to know more detail about his wife's strange disease. The doctor told him that the disease was incurable because the exact cause was still unknown. He added, that the disease would not remain stationary but would slowly progress, eventually end fatally.

After 15 days in the hospital, Mrs. Jones seemed to be recovering from her first attack. Her speech had improved, she was less dizzy although still euphoric. She had been ordered Stelazine 2 mg., twice a day to reduce her muscular tension, and to induce general relaxation. Nembutal was given as a sedative when necessary to induce sleep after a tiresome day.

After three months in the hospital, Mrs. Jones' condition had changed. She had slight, but increasing difficulty in walking and talking. She was embarrassed about her increasing clumsiness when eating or smoking. Her movements were shaky and she complained of occasional flushes of heat and numbness of her feet.

She was given special mouth care after each meal, since she could not clean her own teeth. Her dentures were washed thoroughly with tooth paste or with water and salt. Mouthwashes of glycerine, lemon and hydrogen peroxide were used to rinse her mouth.

Mr. Jones never seemed to believe that the disease was incurable and felt that something more could be done for his wife. For this reason, he requested that she should be transferred to a neurological institute. Arrangements were made immediately. Mrs. Jones stayed there three weeks. Then she was told that her condition was incurable, and was readmitted to our hospital by wheel-chair. There was a little change in her condition. Her right arm and leg felt slightly weaker, she could raise her right hand only for the easiest tasks, and she became more tired when walking. Her memory did not seem to be affected, but there was a moderate loss of sensation in both extremities and slight dysphagia. The doctor noted that she was quick to understand but slow to articulate. She knew what she wanted to say but could not express it quickly enough. She walked more slowly, and required two canes. With help she could extend both arms slowly.

Mrs. Jones continued to have tub baths. Physical exertion was avoided and rest periods planned, to prevent fatigue. Taking a walk in the hall two or three times a day provided an opportunity to exercise her lower limbs. She displayed considerable will power in walking and during the physiotherapy treatments that she received every day. Smoking was a favorite pastime; when a nurse or a neighbor lit a cigarette for her she would smile happily.

Morning care was an important routine. She always wanted to be neat and asked for lotion, perfume and lipstick after her bath and meals. The nurse must be especially conscious of a patient's physical appearance during a long-term illness to help maintain morale. Her hair was washed every second week, and since it was naturally curly, it was easy to set and always looked attractive.

At meal-time, Mrs. Jones needed some help. We cut the meat and potato and prepared her tea. She then preferred to manage slowly by herself and it was important for her morale to allow her to do so. As her condition progressed, her movements became so jerky that she needed help throughout the meal. When the beverage was ready to drink, she leaned over and, without using her hands, took sips of the tea. This was to her great satisfaction — she could still be partially independent!

She was encouraged to empty her bladder at regular intervals to prevent incontinence and discouragement. Three months after her second admission, Mrs. Jones was no longer able to have a tub bath.

She received Maltlevol three times a day as a general tonic. It stimulated her appetite, and was rich in vitamins and iron. Besides Stelazine, Sparine was also given to control increasing agitation. These two drugs produced good results at first, but were less effective as the disease progressed.

From time to time, Mrs. Jones complained about her condition. When she was very depressed, she would cry for long periods. As her speech became more difficult to understand, she became upset and irritable when she tried to talk. On a few of these occasions she refused her medications and her dinner. Her nurse used much patience and understanding in talking with her. When possible she was assigned the same nurse. Mrs. Jones had become accustomed to her; she knew the nurse could understand efforts at speech and she felt less discouraged.

It was very frustrating for the patient to realize that she needed help for the most insignificant activity. Eventually, getting in and out of bed or a chair was a real burden to her. The nurse had to place one foot in front of the other to start her in the proper direction for walking. Her legs were so stiff that she could not begin movement by herself. Once started she was able to walk alone by using a walker. The disease progressed until it involved her swallowing and coughing reflexes as well as her speech. This produced hazards when she tried to eat, often causing her to choke or regurgitate her food. She could no longer control her movements. Even

turning her head from side to side was impossible.

As her husband did not realize nor accept the progression of the disease, he wanted to take his wife home, hoping for better results. Mrs. Jones was discharged for the second time.

In less than a month Mr. Jones once more asked for his wife's readmission. He said that he could not control the situation at home, since his wife was really too ill and required more nursing care than he could give. By this time, Mrs. Jones was bedridden. She had to be fed and washed. Her position was changed frequently to prevent further complications and to give as much comfort as possible. Alcohol back rubs were given at least three times a day, to prevent decubitus ulcers.

The nurses had to invent a trick so that Mrs. Jones could summon help by herself when she needed someone. A string attached to the wall button was passed between her fingers in such a way that just a movement of her hand, even if jerky, would make it work.

Smoking was still her greatest pleasure even though she was unable to hold the cigarette. To protect her from fire and still allow her to smoke, we placed a cigarette holder in her mouth and held it there for her. A nurse always stayed with her while she smoked.

As the disease progressed, the patient was more and more irritable and uncooperative. She cried loudly disturbing the other patients. Tranquilizers were given, in large doses, with poor results. The doctors decided that the chronicity of the illness associated with behavior disorder, would make her eligible for admission to a hospital for mental illness. This was explained to her husband and he understood the situation. A transfer was arranged and Mrs. Jones was discharged for the last time. She died a month later.

Rehabilitation

Rehabilitation means the restoration of the handicapped to the fullest physical, mental and social usefulness *of which they are capable.* This was an important aspect of Mrs. Jones' care. The aims in rehabilitating here were to use and maintain her remaining functions to their fullest capacity.

Physiotherapy was very important. Mrs. Jones went to the department once or twice a day for an hour of specialized exercises. The physiotherapist showed her how to use springs and why they were good for her condition. They had a beneficial effect on the muscles of her arms, giving them an opportunity to be used properly. She did exercises slowly but steadily. The warmth produced was like a tonic for her muscles. The bicycle provided excellent exercise for the muscles of her legs, especially the quadriceps femoris group and the hamstrings.

The patient did not have a wide range of activities. Since she could not use her hands or her eyes very much, occupational therapy was minimal. She could listen to the radio, walk around slowly and especially enjoyed being in a group of people even if she could not participate actively. She really enjoyed jokes and burst out laughing when someone told her a story. Laughing was as good as a medication, since it left her more relaxed and less agitated.

The patient was kept independent for as long as possible. Understanding and patience were particularly necessary. Excessive sympathy and oversolicitude were avoided. They increase the emotional problems and hinder the acceptance and adjustment to the disease. Her family, friends and people around her never showed any emotional reaction to her distorted appearance and postural deformities.

The family, especially her husband, never thoroughly accepted Mrs. Jones' illness. Even though the condition was explained by experienced doctors, specialists and nurses, he always had the impression that something else could be done for his wife to help her recover completely. Supportive measures were taken to lengthen her life, keep her comfortable, and prevent complications.

Mr. Jones was very good to his wife. He did much to maintain her morale and interest in life. He came to see her every day and often walked with her in the hall. He was not wealthy, but she never lacked anything — cigarettes, chocolates, clothing, pocket money.

The Public Health Nurse in Research

EDNA I. LA FLAIR

The public health nurse can play a very helpful role in research and yet retain the feeling that what she is doing is a piece of teaching of definite therapeutic value.

WHEN I WAS ASKED to take part in a study of leukemia at the University of Toronto, my first thought was, "How can I continue to be a nurse in a field that is chiefly concerned with the collection of data and its recording for statistical purposes?" After some thought, it occurred to me that perhaps a great deal of administrative work in public health nursing is compilation of facts, in addition to counselling members of the staff; cooperating with the medical officer of health; interpreting the wishes of a local board or committee; assisting with the formulation of new rules designed to serve the public more adequately, and attending meetings and conferences designed to augment the knowledge of the public health nurse and ancillary staff. I have found that, in this particular piece of research work, it was very helpful to have a good foundation of formal public health nursing education including administration or other advanced university preparation.

The word "research" has many meanings. To some people it means the relentless search for the cause and cure of cancer and is symbolic of the hope of the eventual removal of physical impediments to physical health. The problem must be stated clearly. What has already been done on the project must be reviewed. Following this, hypotheses must be clearly stated and understood; data collected; inferences drawn; conclusions stated, and applications made.[1]

Steps in the Study

When I first started to work on the project, I had a period of orientation devoted to looking up various references in the university library for the professor with whom I was to work. He wisely realized that as a preparatory step, it would be important to learn the ways and means of gathering information. Following this I read as widely as possible on leukemia including reports of the various studies that had been carried out during the last five years, the drugs presently in use, the course of the disease and the experimental work with animals.

Then I was introduced to the director of Medical Records at the Hospital for Sick Children and the chief pathologist, two people with whom we were to work in close cooperation. Letters were sent to medical superintendents or administrators of many hospitals explaining our study. During the year that followed I had the privilege of meeting medical librarians in almost every hospital in Metropolitan Toronto and the surrounding area. Without exception, they were most cooperative and interested in the work we were doing.

I obtained the names of all children who had been admitted to the Hospital for Sick Children since January 1959 and diagnosed as having acute leukemia. In this particular study we were concerned with acute leukemia in children under 15 years. The study continued until December 1960. Letters were sent to the family doctors who had referred the children originally. We explained our study and asked their cooperation if the mother should get in touch with them. We wrote to the mothers, explained our work and asked their permission to telephone and make an appointment for interviews. These interviews took approximately two hours each to complete and were concerned with the medical background of all members of the family. Information was entered on a questionnaire prepared by a medical advisory committee composed of the heads of departments of epidemiology in university teaching schools.

Mrs. La Flair has had many years of experience in the public health field and recently completed further study in administration and supervision.

Who did it

This study of leukemia was under the direction of Dr. Miriam Manning of the Children's Cancer Research Bureau in Boston and was financed by a grant from the United States government. There were 14 centers taking part in the study. The University of Toronto where the work was directed by Dr. W. Harding le Riche, Professor of Public Healtth was the only Canadian university included.

The advisory committee felt that it was important that all interviewers should be public health nurses. This was partly because of their training in home visiting and skill in interviewing, but mostly because of the questions which it was felt would be asked by the parents. One of the points brought out at a meeting of the advisory committee and interviewers in Minneapolis was the fact that here was an opportunity for the public health nurse to do a real piece of teaching of definite therapeutic value. The public health nurse has been trained in observation and in keeping accurate records. She can interpret the doctors' orders, can give advice where necessary, and comfort where needed. Most important of all the committee felt that she was prepared to collect data in a systematic and objective way.

The Interviews

The questionnaire was very detailed. It was concerned chiefly with recording any x-rays and medication that the mother may have had, particularly during the prenatal period. This particular study was trying to prove that leukemia in children may be the result of exposure of a susceptible individual to bonemarrow depressing agents according to present evidence.[2] This information was collected for all other members of the family as well since siblings acted as controls for the index child. The other method of control was to choose a family in the same area, having approximately the same number of children, of comparable ages and birth order, and obtain identical information. It is expected that approximately 1000 case histories will be obtained for study in Canada and the United States. Research workers hope that something definite and useful may emerge from a large-scale comparison of index and control families.

I found the parents, for the most part, eager to help with the study. They had been told definitely and firmly by a kind and understanding physician that their child might live only a few months at the most; that up to the present no cure has been found for leukemia; that the drugs being used definitely prolong life, but that they may have side-effects such as sore mouths and intestinal disturbances, and that if these symptoms occur the drug must be stopped immediately. They knew that there could be a hemorrhage at any time from the mouth or nose or any mucous membrane of the body; that the child might show signs of leukemic infiltration of the lungs or central nervous system; that he might complain of pains in his limbs, of headache, of other signs and symptoms of serious illness; that it would probably be necessary to admit him to hospital several times for transfusions; that he would have to have a blood count taken regularly by his physician; that he might be peevish, irritable and difficult, lose his appetite or have sudden generalized infection. They were advised to keep him comfortable and happy and to be good to him.

It was a privilege to talk to the mothers and see how this crisis brought the parents together. They told of praying for guidance; of really trying to understand the affected child and his brothers and sisters. They realized that it would be no kindness to the child to hurry him from one medical center to another in a vain search for cures. In only one instance had the mother refused to accept the diagnosis.

I found many opportunities to counsel both mothers and fathers. Very often the father asked if he could be present at the interview and, on several occasions, left his place of work to do so. Discussions included preschool care, diet and management, meals for school-age children, infant care and feeding, and teen-age skin conditions. The management and care of husbands seemed to be a major problem in some homes! In many cases it was necessary to refer the mother to her physician, to the local health department, to a social agency, or to her clergyman.

Often, the mother poured out her feelings of guilt, of inadequacy. "What could I have done to prevent this?" One mother blamed her husband for her child's disease, since he was "always sick," always "bringing home colds," and the child always contracted them. (In leukemia, the white blood count rises from about 6,000 per cubic millimetre to 150,000 or more per cubic millimetre. Since the cells are immature, the ability to throw off infections is lost.) Another mother was sure that the reason for her child's illness was because she had not wanted a baby. When she first became aware of the pregnancy she had been very angry and upset. She felt that God was punishing her.

Verifying Facts

Following the home visit it was necessary to verify all information concerning x-rays and medication. In this connection, letters were written to distant hospitals, physicians and dentists. Visits were made to local medical record departments and physicians' offices. There was very excellent cooperation from doctors and dentists in supplying necessary information concerning index and control families. In many instances letters were enclosed with reports indicating their interest.

Control Families

Many unusual situations arose in the search for control families. This, in itself, was an interesting experience. The advisory committee ruled that the best possible way to find a random family, was to start at the first house to the left of the index family, knock at the door, explain our study, and ask if there were the required number of children. If, by any chance, all requirements were met by this family and the mother was willing to answer the questions and help with our study, then our difficulties were over. However, nine times out of ten, the family was not suitable and we asked the mother if she knew of a family that was. Usually, she knew at least two other families who might meet the requirements and we would go to the first one and knock hopefully at the door.

It was somewhat frustrating to try to explain the purpose of the study through a two-inch crack in the door and attempt to ask the mother to help us with this bit of research. We were mistaken for magazine salesmen, book agents, newspaper reporters, bill collectors and welfare investigators. The only thing they were sure of was that we were not working our way through college!

The magic words in every case were "public health nurse." The door opened wide, the mother smiled and said "Come in, I've been wanting to ask somebody about John!" On another occasion a woman whom I was particularly anxious to interview was at the telephone. She asked me to state my business and to be quick about it as she was on the telephone. I smiled and said "public health nurse" so she said "Come in and sit down," — which I did, on the stairway in the hall. Twenty minutes later, after a most interesting one-sided conversation about husbands and children, she suddenly said, "Oh my goodness! There's a public health nurse sitting on the steps, I want to ask her about Mary!" Perhaps one of the most important attributes of a public health nurse in research work is patience!

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Education must give value to man throughout his life, give him the means and the skills that will permit him to enrich himself and to live fully, to contribute to that which ascends a slope, rather than descends.

— CHARLES H. BARBIER

The function of education is to make men, responsible and interdependent men, so that each one of them may raise himself to a full personal life and together they may create a full social life.

— GEORGES FAUQUET

PSYCHOLOGICAL NEEDS

JACQUELINE A. PEITCHINIS, M.Sc.

For some considerable time, nurses have been writing and talking about meeting our patients' psychological or emotional needs. In practice, we attempt to do so. But do we know, in fact, what these needs are and how they can be satisfied?

IT SEEMS HIGHLY improbable that we can have complete understanding of our patients' emotional needs since many of the learned psychologists do not agree on what they are. Some tend to postulate one basic need or tendency, while others propose a variety of them with H. A. Murray's list of psychogenic needs adding up to a grand total of twenty-eight!

There are other opposing lines of research. One worker attempts to maintain that psychological needs are derived from physiological needs and are thus secondary in nature. Another hypothesizes that human beings are so made as to have certain psychological needs which can be fully satisfied only in association with other people. In addition, reams of material have been written on drives, incentives, instincts, instinctoid tendencies and the like. Some researchers even attempt to establish differing psychological needs for men and women.

All of this can be very confusing to the uninitiated nursing student. What is even more disconcerting is the unfortunate fact that some instructors have been guilty of presenting one particular point of view, leaving the inexperienced hearer ignorant not only of the evidence in support of different viewpoints, but almost of their very existence. Admittedly, the writer's allegiance is directed towards a particular hypothesis. The evidence for it as reviewed thus far seems convincing and challenges one to further investigation of the concept of need as presented by the British psychologist, Dr. C. M. Fleming.

FORMS OF EXPRESSION AND EXPERIENCES ASSOCIATED WITH PSYCHOLOGICAL NEEDS

In her concept, psychological needs are:

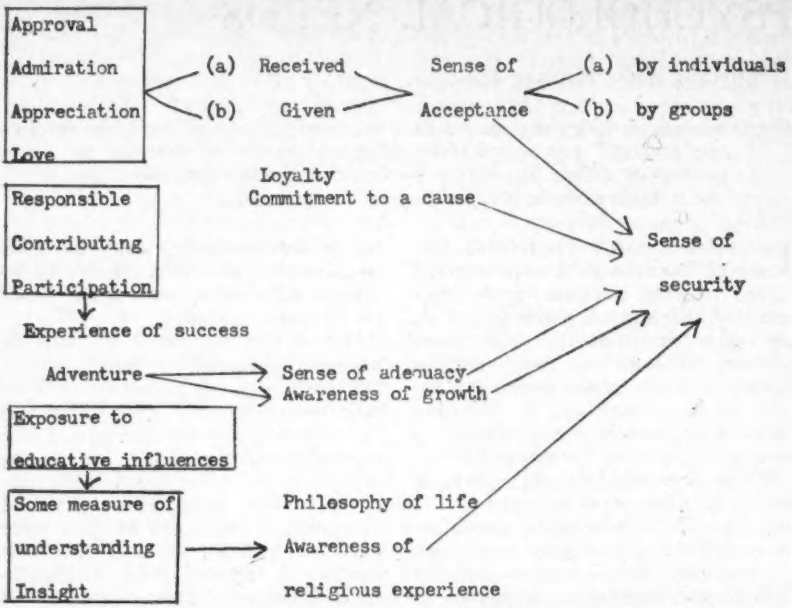
> . . . those psychological requirements which are common to all human beings by virtue of their humanity. The most significant of these would appear to be:
>
> the receiving of appreciation or affection, (experiences of being beloved);
>
> the sharing in cooperative endeavor, (opportunities of making a contribution or participating)
>
> and the conditions contributory to growth — the meeting of new experiences, the chance to attain some measure of understanding or insight, and the exposure to suitable tuition in informational or other educational experiences . . .

Relating this concept to nursing we have

> a social approach to human beings, admitting their need for appreciation and participation. A liberal-minded attitude to the . . . art of nursing . . . with awareness of the significance of insight and the part played . . . by patients' and students' concepts of themselves. Because the content of the picture one has of oneself (as a person, and in relation to other people) is definitive for conduct, the ultimate test for education and for therapy lies in the modification they effect in the personal attitudes of pupils or patients.

Mrs. Peitchinis, a Canadian nurse, was working in England and pursuing further study in educational psychology and sociology at the Institute of Education, University of London. She is presently in London, Ont.

For those who are interested in pursuing this line of thought more deeply, Mrs. Peitchinis has supplied a very comprehensive list of references. It is available on request.



Forms of expression and experiences associated with psychological needs from C. M. Fleming.

For further evidence we look first to the printed page. We find it in many different places from scholars of seemingly diverse disciplines: Doctors and nurses, an anthropologist who writes from personal experience in Africa, a philosophical writer in Australia, a former university professor, a director of counselor education and professor of education and many others.

We also seek support from patients — one can learn much from them — and others whom we have known. Perhaps the reader finds some evidence in his or her own experience. One cannot help but recall the misunderstood paralytic "problem patient," hurt and hitting out in every direction. He turned out to have been a very unhappy adolescent with seemingly insurmountable personal difficulties. What wonders can be accomplished with the help of an understanding nursing student! What fascinating things a clergyman can help an expert surgeon to discover! Imagine the feelings of the "incorrigible alcoholic" who came to feel that someone believed in and trusted him! It is wonderful what an understanding doctor can teach an experienced rehabilitation officer. How exciting to recall what a quiet, unassuming physiotherapist and her patient can help a blustering orthopedic specialist to discover — and how much the nursing student learns from all of them!

Nor should we forget what students can help their teachers to realize. Remember the medical student, a star football player who asked the health team when they were going to stop sitting around *talking* about their patient and get busy and *do* something to help him! We think too of the aspiring young doctor who always managed to do the wrong things in the operating room; the distraught student nurse who was certain that she would never earn her cap; the one who was equally sure that she would never pass a qualifying examination; success came to all of them. One recalls that old Irish proverb "two-thirds of help is to give courage," or the English one "if it were not for hope the heart would break."

One could never forget the somewhat anxious, elderly war veteran who was leaving hospital after recovering from a partial gastrectomy. "You know, nurse, the doctors have their

jobs to do, and you nurses have yours, but the patient has his too . . ." He might well have been saying: "Skilled surgeons removed part of my stomach to correct a pathological situation; experienced nurses dressed my wound, kept my fluids balanced, enhance or counteract certain physiological or biochemical processes, but, in fact, it was I who healed this incision."

By way of summary the following assumptions are presented:

A. If patients are to be understood and helped, they must be loved and liked, not as particular "cases" but as human beings with potentialities for growth towards higher levels of healthful living. They must be granted opportunities to understand and to participate in their own recovery and development. No one likes being told what to do. It is so much more meaningful to make one's own decisions, and who knows, one might give the wrong advice!

B. If nursing students, assistants and aides, graduates and the hosts of other learners in health centres are to be understood and helped towards increasing professional effectiveness, then *they* must be appreciated. They must be given the time and facilities to explore and experiment, within safe limits and with the guidance of experienced teachers, in the countless learning situations that their patients bring to them. How fascinating to contemplate what this approach might do to student drop-out rates, and the rather rapid turnover of general duty nurses about which one hears so much?

One word of warning. If nurses, teachers and administrators accept responsibility for creating the conditions in which patients, students and staff are to achieve the most, and develop themselves the most, some consideration must be given to their own motivation. No one appreciates, for example, the "affable manipulation of consent" or the "I know what is best for you," approach. This article is one hypothesis regarding the nature of psychological needs and a few of the factors involved in their satisfaction. What has been suggested probably will not work unless, ". . . it squares with your basic philosophy" regarding the nature of human beings.

(Continued from page 653)

Margaret Jane Finlayson, a 1924 graduate of Belleville General Hospital, Ont. died on March 29, 1961.

* * *

Agnes Josephine Horan who graduated from the Ontario Hospital, Orillia in 1935 died in Toronto on April 5, 1961.

* * *

Mary Lamplough, a 1916 graduate of Jeffery Hale's Hospital, Quebec City died in the Colonel Belcher Hospital, Calgary after a long illness. During World War I, she served overseas with the C.A.M.C. for a period of five years.

* * *

Isabel McLaurin, a 1916 graduate of the Lady Stanley Institute, Ottawa died on April 7, 1961.

* * *

Donna Ann Morrison who graduated from Greater Niagara General Hospital, Niagara Falls in 1959 died on April 9, 1961 from injuries received in a car accident.

* * *

Helen Todd (Hutchison) McCracken who graduated from the Dauphin General Hospital, Manitoba in 1935 died suddenly in March, 1961. She was matron of Pine Falls Hospital, Manitoba.

* * *

Julia B. O'Connor, a 1908 graduate of St. Michael's Hospital, Toronto died on April 13, 1961.

* * *

Doris (Craig) Peters, who graduated from Stratford General Hospital in 1934 died in February 1961 after a lengthy illness.

* * *

Rose Anne Vandervoort, a 1960 graduate of Belleville General Hospital, Ont. died on April 9, 1961 from injuries received in a car accident.

We call the genius of a language, its aptitude to say in the shortest and most harmonious way what other languages express less clearly. — VOLTAIRE

THE RURAL HOSPITAL
Looks at the New Graduate

MARGARET M. AIKENHEAD

Today, we have evolved many standards and norms controlling not only the level of care, but the training of those giving this care.

IN DAYS LONG PAST, the care of the sick was a sporadic endeavor. Generally, it was given under the sponsorship of the church by dedicated lay people who set their own individual level of effort and attainment. The looseness of this pattern could offer no standard of care beyond that achieved by the individual donor.

In Saskatchewan, we have approximately 146 general hospitals: 12 have over 100 beds; 26 have 30 to 100 beds and 108 have 8 to 30 beds. This will offer some indication of the incidence of the rural hospital. Approximately 50 per cent of the graduate nurses working in hospitals, are employed by institutions of 100 beds or less. The remainder work in hospitals with schools of nursing and teaching personnel.

Today, nursing is no longer an isolated aspect of the care of the sick, but is a positive sector of the service which we think of as the combined effort of many hospital employees, each of whom is an essential factor in its attainment. In these busy days of per diem cost, team concept, total budget, departmental budget, changing work hours and the expanding curricula, it is sometimes difficult to remember that the patient is still the most important person and, in effect, the prime purpose of our hospital's existence. We are sure that those charged with the planning and implementation of nursing education must face tremendous decisions. Should we attempt to develop in each student an ability to know and use her own practical potential? In short, where is nursing headed? Are we moving in cycles or going in circles? How closely does our pattern of education fit our students for the requirements of those who will employ them?

At present, there are about 60,000 nurses in Canada actively contributing, directly or indirectly, to nursing service. Let us consider the qualities in the new graduate looked for by each of the following:

1. The hospital board and administration
2. The patient
3. Co-workers and medical staff
4. The local community.

The Hospital Board

Development of a good level of nursing care depends on well functioning nursing, laboratory, dietary and laundry departments, etc. Administrative levels must plan and coordinate the efforts of all these departments. This is a responsibility delegated by the board of directors. It also includes provision of a nursing staff capable of answering the needs. Hospitals are charged with meeting increasing demands in health care, prophylaxis and research. To help meet these demands the hospital board wants nurses, capable of loyalty, who can conform to requisite standards and legal aspects.

As administrators we often wonder if the new graduate realizes how much her letter of application tells about her as a person. We cannot expect all graduates to be specialists, but we do feel that they should be familiar with the over-all picture in their own school and know a little of how the different hospital services coordinate. This basic visualization is most valuable in *any* future field but it is particularly advantageous during orientation in the rural hospital. The new graduate generally needs three to four months before she begins to be valuable to her new employer. Should she be faced with pinch-hitting for a more senior nurse because of illness or some such cause,

Mrs. Aikenhead is director of nursing at Melfort Union Hospital, Melfort, Saskatchewan.

even knowing where to look for help is a great advantage.

With consideration being given to shortening nurses' courses and widening their scope, we believe employers would welcome positive extension programs in nursing education— requisite refresher or supplemental courses at least once in each two years. This would help to keep nursing up-to-date with the other helping professions and promote a "continue-to-learn" attitude.

The hospital board contracts to pay a nurse a certain definite salary. In return, it rightly expects from the nurse full value for the investment. She assists in providing and achieving a complete service to a community. She must practise adequate and protective health measures in the interest of patients and staff and use all available teaching opportunities. She must give positive attention to, and at all times provide service in, the best interest of the patient and hospital, while considering the use of personnel and supplies. Introduction of students to the visual facts of cost would be most helpful.

The board frequently provides living accommodation for the nurse at lower than local cost. This privilege the nurse should respect by accepting the regulations accompanying such provision. What is not permissible in her own home is not permissible in the residence! The hospital board is quite anxious to establish stability in nursing service. Toward this end it would welcome terms of duty of at least one year. In general education one-year terms of employment are requisite in order to establish continuity. This continuity is equally necessary in the care of the sick.

In summary, the hospital board and administration will truly appreciate the nurse who, at all times, supports the hospital employing her services, and who realizes that in accepting this employment she has certain obligations, moral and legal, to fulfil.

The Patient

On entering the hospital the basic, overwhelming feeling of most patients is fear — fear of pain, fear of expenses, fear of responsibilities at home, etc.

Much has been said of the function of today's nurses in patient care. The evolution of principles and practice in nursing arts has not changed the need for skill and manual dexterity. An issue of *The Canadian Nurse* discusses this in a thought-provoking article questioning whether we have a shortage of *nurses* or *nursing*. It is our belief that we need not do a routine function a multitude of times to produce capability, but we do feel we need to cultivate in our students the ability to practise skilled professional care. To ensure this, we need adequate supervision in early clinical experience so that the student may see correlation between theory and practice. We feel that the bedside presence of a well qualified nurse is reassuring to patients and is desired by many of them. This same reassurance is present where the skilled nurse quietly recognizes the emotional and physical needs of the patient and can accomplish the purpose for which her nurse-patient relationship exists.

Some schools find time for special classes in psychodynamic nursing. I feel that these added techniques are certainly advantageous to patient and nurse. The nurse who will make the best contribution must first understand her own capabilities and purpose. Her day's duty may call for her to be an interpreter to and from the family for her patient and will gradually let her assist in the projection of this particular illness into the home picture. Better understanding between doctor and patient can be a direct result of nurse-motivated coordination. When need for spiritual assistance is expressed, the nurse must be prompt to relay this need to those who will arrange for it. The patient looks for a nurse who can and will direct and participate in an atmosphere of quiet. Quietness in itself produces a soothing effect on the patient and at the same time causes us all to function more efficiently.

Any patient responds to a genuine personal interest. He expects his nurse to be adequately informed on aspects of his particular illness and its implications, and to discuss them in the ethical bonds of doctor-nurse relationship. At times, perhaps, this is as important to the patient as the carrying out of the many skills involved in his care. Having once established confi-

dence in his nurse, the patient is more apt to reach for the levels of adjustment and recovery to which she may direct him. It has been said that in the care of the sick, compatibility of emotions can be just as essential as the fine techniques of a donor match. Today, with our frequent changes of personnel and staff, the nurse must be especially mindful of this.

The Medical Staff and Co-workers

Quite often the new graduate steps from a controlled student situation into an environment where she is expected to function as a complete unit. This sudden metamorphosis is not without some pangs especially where the nurse is also submerged in reorientation. Verbal reporting of pertinent observations directly to the doctor by the nurse sometimes presents problems. Accepting dictation of emergent phone orders and being able to interpret and apply them is also difficult if a nurse has not had adequate student experience in this area. Medical staff must be reminded to write orders and to sign them. This often requires tact and firmness beyond the accepted scope of the student.

The doctor expects courtesy and efficiency combined with a genuine interest in his patient. He expects reports of occurrences that will enable him to better evaluate the needs of the patient, and he looks to the nurse to relay this information. When emergencies arise, as they do, the doctor expects the nurse to contribute to the situation without complaint even though she felt the day had been a hectic one. The doctor appreciates a nurse who has a good basic knowledge of drugs and techniques and who is not afrait to ask for interpretation, should she have need of this.

Third year review of pharmacology would help the nurse in making use of reference materials. Stock solutions for drugs are not in use in all hospitals, so the nurse needs to know alternate techniques. We must promote in her the desire to keep abreast of what is new in drug therapy. Good intercommunication between doctors and nurses will assist with this problem. Most doctors respond well to intelligent questions on new drugs and techniques, and this practice must start at the student nurse level.

The operating room and the case room are areas where there is again direct doctor-nurse contact. We find these services are ones to which the new graduate often asks not to be sent. We must hasten to add that this is not evidence of a lack of knowledge or capability, but rather appears to be due to a lack of opportunity to develop personal confidence under supervision as a student. Perhaps opportunity to assist with administration in the senior term would help the nurse to develop the confidence the doctor anticipates.

The business office is a source of worry to the nurse in the smaller hospitals. It is felt that nurses understand very little about minimal business practice, and sometimes this is too true. Co-workers in the office, especially, would like nurses to know why the receipts are numbered and why certain pertinent forms must be completed with the recipient of the service present. During the night shift, the nursing staff is sometimes required to assist in this area. I used to feel that one could not be an "angel of mercy" with one hand and a financier with the other. Today, I realize that while we may be motivated by charitable impulses, we must operate our hospitals on a business basis. For example, knowing how much it costs to keep a patient in an oxygen tent for 24 hours will help the nurse to remember to shut off the line valve when the patient is temporarily out of the tent. Again, we do not expect a course in business administration for the nurse, but she must know where she can help those who must account for our financing and records.

Co-workers in the patient care team want a nurse who can meet average situations independently and who is willing to learn new techniques or ask for assistance. The good nurse will show interest in improving her own knowledge of the hospital and will learn why certain policies are practised. This will vary from hospital to hospital due to local needs.

Co-workers prefer the nurse who can share in all duties, pleasant and unpleasant, and who will display willingness to help others who have had less opportunity for training. All of this the nurse must do in an atmos-

phere of loyalty. Human feelings, trust and empathy must keep our hospitals from being impersonal while maintaining high levels of ethics and professional attitudes. We feel the nurse is the person in the patient care team capable of giving directives, while practising courtesy and good manners both to her patients and her co-workers. Laundry, dietary, laboratory, housekeeping deparments, etc. all contribute to patient care. We as nurses must be prompt to recognize and appreciate that without these co-functions many phases of our effort would be impossible. No matter what her capacity in any hospital, what each one does is important to that hospital. Let the nurse be prompt to express appreciation of and to co-workers.

Community Aspects

There is much the nurse can do to foster good relationship by meeting the patients, family and visitors satisfactorily. This may mean interpreting policy or giving reassurance to a patient or relative as the case may be. Many personal skills in public relations need to be developed in a manner that cannot always be learned from books. Especially in the rural areas, we must realize that we actually live a large portion of our public relations on and off duty. Those who have worked in rural areas will recall that everyone knows when an employee of the local hospital appears. One poor apple can label the barrel!

We sometimes hear it said that nurses are restless and unsettled because they are not sure of where they are headed. This may be so. Sometimes we feel that nurses are unsettled because they are segregated from community patterns. Spending three years in residence where one is protected and provided for completely, somewhat removes the nurse from the reality of costs. Here we feel that perhaps the trend toward nurse internships, where the young women pay in dollars and cents for maintenance, will provide a much happier and more adjusted independent type of nurse with a better appreciation of money values. Knowing basically some of our provincial and local social services and their functions will also help the nurse to visualize the patient in the community outside the hospital.

Often the young nurse closes the door on community service opportunities apart from her own work. Her reasoning may be: "I'll only be here for a few months and I don't want to be tied down." We feel that that nurse is missing the human contacts she needs to be a complete person. Among our nurses we have a great deal of talent — music, church leadership and sports, to mention only a few. Nurses should become members of a community and mix with other groups to remember how people live who aren't in residence. It's so easy to sit comfortably in the seclusion of the residence to watch T.V. instead of participating in community activities. We have all done it!

Red Cross, Cancer Society, Mental Health, volunteering for special clinics, helping with C.G.I.T., Cubs or Brownies, joining choirs, are just a few of the things a nurse can do to reach into the community. It is our belief that any effort involved will be more than repaid in the esteem with which such work is met, to say nothing of the personal satisfaction. Let us teach the nurse to look for new horizons in off-duty intercommunication, which will take her beyond the patient with the cholecystectomy in 215 or the gastrectomy in 113.

We are not advocating a larger and longer curriculum! Rather, let the student recognize the applied practicality in everyday living of the principles we now teach. In this way we can keep nursing human and applicable.

The homemaker who is attempting while shopping to get the "best buy" can be seriously duped when she buys what she thinks are fruit juices but if she looked more closely she would find are labelled fruit *drinks*. This difference of one word on the label, sometimes can mean the difference between a product that is less than 10 per cent fruit — with the balance sugar, acid and water — and a product that is 100 per cent genuine juice.

— *CAC Bulletin*. Feb., 1961

A Master's Program in Nursing at McGill University

NURSES across Canada will be pleased to know that McGill University has established a program in nursing leading to the degree of **Master of Science** (Applied). The program is under the direction and control of the Faculty of Graduate Studies and Research, as are all courses leading to higher degrees in the University. Every student admitted will be attached to the School for Graduate Nurses which is primarily responsible for guiding her studies. The Kellogg Foundation has underwritten the major part of the cost of the program for the next five years.

Recognizing the need for advanced preparation in nursing, particularly for teaching and administrative positions, many nurses have acquired this preparation in American universities and are grateful for the help they have received from these institutions. However, there has long been a feeling that more nurses would seek postgraduate study if master's programs were offered in Canadian universities. This feeling was reflected in a resolution passed unanimously at the Canadian Nurses' Association Biennial Meeting in 1958, which requested our national organization to urge Canadian universities to establish programs in nursing at the master's level. The need for more well-prepared people has been accelerated by the rapid growth of hospitals, the extension of public health services and the advancement of knowledge in medicine and related disciplines.

The aim of this new program at McGill is to prepare nurses for the responsibility of intellectual and professional leadership in teaching, administration, research, and the practice of nursing. Students will elect to major in Nursing Education or in the Administration of Nursing Services in Hospitals or Public Health Agencies. Certain courses considered essential to the development of sound concepts in all areas of nursing will be required of every student. The curriculum is based on the analytical approach to nursing and to the needs of patients and their families. Considerable emphasis is placed on the social and behavioral sciences and students are expected to select a number of courses from the fields of sociology, anthropology and psychology. The program is flexible enough to meet the objectives and to build upon the past experiences of the individual student.

The program covers a period of two academic years with an opportunity to complete most of the course requirements in the first year. Following the completion of the course requirements, students will spend a month in a clinical area in a hospital, or in a public health agency, identifying important elements in nursing care. During the second year, each student will undertake a Research Report and will spend considerable time in the clinical field collecting her data. However, it is felt that some students will be able to do part-time work during the second year.

Despite the fact that this announcement is late and so gives senior nurses little time to make arrangements for leave of absence, it is our hope that a small group will enrol in September. The registration date is September 21st. A few bursaries are available through the School for Graduate Nurses.

RAE CHITTICK

Immediate confirmation of hotel accommodation at all Canadian National hotels is possible under a new system now in effect.

Described as the "free sale reservation system," the new plan enables customers in most major Canadian cities to walk into or telephone a CN ticket office and obtain an immediate reservation at any CN hotel in Canada. The plan applies also to the CN-owned Queen Elizabeth Hotel and the jointly-operated Hotel Vancouver. Reservations can be made three months in advance.

Book Reviews

Sea Within, The Story of Our Body Fluid by William D. Snively Jr., M.D. 150 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1960. Price $3.95.
Reviewed by Miss Irene Nordwich, 1289 Wolseley Ave., Winnipeg 10.

One characteristic which seems to be common to all true men of science is their sense of reverence and humility in the face of the vastness and magnitude of life and its Creator. Such a feeling is strongly conveyed in this book. Students of the human body, laymen and professionals alike, will welcome warmly a presentation of one of the most difficult topics in the field of physiology: a subject which forms the foundation of understanding homeostasis — the fluid balance of the body and the forces that affect it favorably or adversely, thus tipping the scale of our very existence.

The dynamic and imaginative language captures the reader's imagination from the start. It helps him to form an image of the hitherto mysterious workings of the body. He will find it refreshingly free of complicated technical terms and involved "thesis type" phraseology. Skilfully, the author creates a link with our shadowy, biological ancestry. Simple, straightforward scientific facts allow us to follow the evolutionary forces of the past with relative ease. Many analogies taken from everyday life make the approach to the subject matter direct and clear, but never dry. The reader retains the sense of adventure that compels him to go on reading.

Numerous diagrams are placed strategically throughout the text. Many of the drawings are comparative in nature and are placed on adjoining pages so that they are easily accessible for a quick analysis. The use of italics in the text helps to emphasize important points. Fundamental facts are frequently set in heavier print in the center of the page allowing for easy note-making and summaries.

To reinforce understanding of present conditions in the body, short "flashbacks" are inserted to show how such a system or function has developed in the light of the theory of evolution and how it gradually fitted into its assigned place in the body machinery. As the reader progresses through the book all conceivable dimensions of body physiology are expertly explored and brought into meaningful relationships. This culminates in a surprisingly clear understanding of the body's constant struggle for balance, so necessary to survival. Thus the narrow margin that often exists between the normal and the abnormal comes into the spotlight.

A few references are given, enabling the more ardent and inquisitive student to pursue certain aspects of the subject in greater detail. Perhaps some of the readers, particularly those engaged in teaching in the field of nursing would appreciate a more extensive list of references.

Bearing in mind the fact that the management of electrolyte and fluid balance of the body is a factor of growing importance in the management of the sick individual as well as in the field of preventive medicine, this book should not only provide adequate and accurate information but, by virtue of its presentation, make it possible for the person hardest pressed for time to use it economically and fruitfully.

Medicine in the Making by Gordon Murray, M.D. 235 pages. The Ryerson Press, 299 Queen St. W., Toronto. 1960. Price $5.50.
Reviewed by Miss Mary Rowles, Director of Nursing, Royal Inland Hospital, Kamloops.

In his foreword, Dr. Murray tells us that he was inspired to write this book by friends whose opinion was that "a lay description of research projects would inspire those in the process of selecting their professions, and might interest some other readers." In a framework of biographical material, school work, war experiences and postgraduate study in other countries, the author relates the story of his research projects. The reader is shown the problem, the period of research, and the final solution. To add interest for the layman, these descriptions are brought to life by the histories and treatment of some of the first patients.

The whole story of research moves against a cosmopolitan background. When Dr. Murray returned to Canada in 1928, he brought a wide knowledge acquired in Britain and the United States. His accounts of medical practice and research in the London and New York of 40 years ago are revealing, as is also his comparison of the two cultures as applied to medicine. The culmination of recognition in his profession came in 1939 when he was invited by the Royal College of Surgeons, England to deliver the Hunterian Lecture. With becoming modesty, this event is described as a pleasant interlude in the important months and years of research.

This is a book that will interest every nurse in Canada. Apart from the information provided on such varied subjects of research as early cardiac surgery, early work in anticoagulants, complicated fractures and the uses of heparin, we are privileged to read of original work performed in Canada by a Canadian. This fact alone should make the book a required addition to the nursing school library. However, I feel that it will be best enjoyed by certain specialized groups, and that it is not a book for the average layman. Thus, certain chapters may be assigned reading for the advanced nursing student, but would not be suitable for a preclinical class. Counsellors at the college level may find it a useful reference. For all who are studying allied subjects, this book will liven the pages of the normally dry textbook, and may indeed be the cause of inspiration to those whose professional future is still undecided.

EMPLOYMENT OPPORTUNITIES

General Duty Registered Nurses for commencing duty May, June & July at $325 per mo., plus by-yearly increments. Paid holidays & sick leave, room & board $30 per mo., group medical & hospitalization plans. Apply: P.O. Box 339, Spirit River, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $285-$335 gross salary for Alberta registered, $275-$325 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

General Duty Nurses (preferable with operating or case room experience), for busy 20-bed hospital. Salary $285 with recognition for experience. Accommodation in new, separate residence $30, 28-days vacation after 1 year, 40-hr. wk., Apply to: Miss A. M. Morrison, Matron, Municipal Hospital, Bow Island, Alberta.

General Duty Nurses — starting salary $290 per mo., 40-hr. work wk., board, room & laundry available, if desired, $30 per mo. Civil Service holiday, sick leave & pension programs. Apply to: Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurse for 16-bed hospital, starting salary $285 per mo., 40-hr. wk., board & room $35, uniforms laundered free. Municipal Hospital, Elnora, Alberta.

General Duty Nurses Salary $285-$315 per mo. plus other benefits, 40-hr. wk. Train fare from any point in Canada will be refunded if employed for 1 year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta, PHONE 335.

BRITISH COLUMBIA

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write. The Administrator Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $297 to $359. Pre-planned shift rotation, B.C. registration essential 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses (2) for very active 32-bed modern hospital; RNABC salary schedule & personnel policies — unregistered $282, registered $297-$359 (annual increments) 40-hr. wk., pension & medical welfare plans, cumulative sick leave, 4-wk. vacation plus 10 statutory holidays; residence in hospital grounds. Apply: Director of Nursing, General Hospital, Ladysmith, Vancouver Island, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $307, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $297, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. Very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses, Operating Room Nurse (1) (with postgraduate or equivalent) for July 1st. in very active 146-bed General Hospital. Required October 1, 1961 **Head Nurse** for women's Medical & Surgical 27-bed nursing unit. Personnel policies in accordance with RNABC. Rooms available in nurses' residence. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses, Operating Room (1), Obstetrics (2), Medical & Surgical (1), for 130-bed hospital on beautiful Vancouver Island, within easy reach of Vancouver & Victoria. New hospital under construction. RNABC policies in effect. Apply to: Director of Nursing, General Hospital, Nanaimo, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $297-$359. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

ONTARIO

Public Health Nurse (Qualified) for generalized program in town of Elliot Lake. Salary range $4,200-$5,250, annual increment $210, allowed $100 per year to maximum of 3-yrs. for past experience. Provide own transportation. 5-day wk., 4-wk. vacation, group insurance, hospitalization & P.S.I. employer shared. Apply to: Dr. J. P. Moody, Medical Officer of Health, 46 Ontario Ave., Elliot Lake, Ontario.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for positions in Hospitals, Outpost Nursing Stations and Health Centres in the Provinces, Eastern Arctic, Northwest and Yukon Territories.

SALARIES

(1) Public Health Nursing Supervisor II — $5,100 to $5,460 per annum

(2) Public Health Nursing Supervisor I — $4,620 to $5,160 per annum

(3) Directors and Assistant Directors of Hospital Nursing Services:

- a) Classification III — $4,860 to $5,400 per annum
- b) Classification II — $4,350 to $4,860 per annum
- c) Classification I — $3,900 to $4,560 per annum

(4) Public Health Staff Nurses — $3,600 to $4,050 per annum

(5) Hospital Staff Nurses — $3,300 to $3,750 per annum

(6) Certified Nursing Assistants, Licensed Practical Nurses and Nurses' Aides: up to $2,400 per annum depending upon qualifications and location of positions.

• Room, board and laundry in residence at reasonable rates. Statutory holidays. Three weeks' annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $285 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses (urgently needed) for new modern 50-bed hospital in Central B.C. town, salaries $312 B.C. Registered, $297 for non B.C. Registered. Room & Board $50, golf, curling, bowling, roller-skating, swimming at local Hot Springs for entertainment. Apply to: Director of Nursing, Terrace & District Hospital, Terrace, British Columbia.

Graduate Nurses (4) immediately for 40-bed hospital. Salary $300 per mo. for B.C. Registered Nurses & $15 less per mo. for non-registered nurses. 3 yearly increments, 40-hr. wk., 1½-days sick leave with pay per mo., 28-days vacation with pay after 1-year of employment & 10 legal days per year. Fare from anywhere in Canada advanced & need not be repaid if you stay 6 months. Superannuation benefits, uniforms are laundered gratis by the hospital. There is a new modern residence which is available for $45 to $50 per month. Interesting social advantages as an excellent Choral Group, excellent educational opportunities and good sporting, Skating, Bowling, Fishing, Boating, Curling, Hunting, etc. Kindly apply giving references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

Operating Room Nurse with postgraduate course for active operating room in General Hospital with School of Nursing. Salary $297 plus increment for experience. Must be eligible for B.C. Registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Nurses with postgraduate training for modern, active 125-bed hospital, personnel policies in accordance with RNABC. Basic salary $297, rooms available in new nurses' residence. Apply: Director of Nurses, Regional Hospital, Prince George, British Columbia.

Nurses for small active hospital. Minimum salary $310 per mo., yearly increments, allowance made for experience, room & board $35 per mo., refund on fare after 6-mo. $50. Write or phone, Matron, General Hospital, Fort Nelson, British Columbia.

General Duty positions available for Summer relief in all services, also several permanent positions. Basic salary $297 per mo., B.C. registration required, excellent personnel policies. For further details apply to: Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

MANITOBA

Matron (Immediately) for 35-bed hospital in Southern Manitoba. Starting salary $350 per mo. 40-hr. work wk., separate residence with room & board available at $45 per mo., free laundry services. Apply with references to: O. Hamm, Administrator, Altona Hospital District No. 24, Box 660, Altona, Manitoba.

Matron (1) duties to commence immediately. Salary $370 per mo. **Registered Nurse for General Duty** (immediately) salary $310 per mo. For both positions $5.00 increments every 6-mo. for 4-yrs. less $45 per mo. full maintenance, living quarters in hospital. Apply to: Medical Nursing Unit, Birch River, Manitoba.

Registered Nurses (2) or 1 Registered Nurse & 1 Licensed Practical Nurse for 18-bed hospital in western Manitoba. 40-hr. wk., starting salary R.N.'s — $305 per mo., L.P.N.'s — $215 per mo., board & room available $45 per mo. For further particulars & application forms please write: Miss Avis Haymen, Matron, Medical Nursing Unit, Rossburn, Manitoba.

Registered Nurses (2) Practical Nurses (2) for 29-bed hospital near Winnipeg. Salary $315 & $215 respectively. 40-hr. wk., vacation pay, 10 statutory holidays, paid sick leave, room & board $45, $10 increment yearly. **Registered Nurse** (1) with supervisory experience to assume duties of Director of Nursing by September 1961, commencing salary $360. Apply to: Administrator, De Salaberry Hospital District No. 27A, St. Pierre, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NEWFOUNDLAND

Registered Nurses for General Duty & Operating Room for 100-bed hospital. Nfld. Government salary plus $150 bonus end each 6-mo. service. 2-wk. paid vacation after 1-yr., 8 statutory holidays, one-way transportation paid. Apply to: Nurse-in-Charge, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland.

NOVA SCOTIA

Registered Nurses for General Duty for 21-bed hospital. RNA of Nova Scotia policies in effect. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbor, Nova Scotia.

General Duty Nurses (Immediately) **Registered Medical Record Librarian** (1) **Dietitian** (1) experienced **Operating Room Nurse** (1) for 75-bed hospital. Salary according to RNA of N.S. Comfortable living conditions. Apply: Superintendent, Highland View Hospital, Amherst, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing for modern 75-bed hospital. Attractive growing town of 5,500. Starting salary dependent upon qualifications & experience. Please enclose references, give full particulars & date available in letter to the: Secretary, District General Hospital, Dryden, Ontario.

Supervisor (evening & nights) for 160-bed hospital, 5-day wk., excellent personnel policies. Hospital of Ontario Pension plan, residence accommodation available, assistance with transportation can be arranged. Apply: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses $300 per mo. min. to max. $340, 3-weeks vacation with pay, sick leave after 6-mo. service. Non Registered — $15 less, Cert. N.A. $210 min. to max. $240, 2-wks. vacation with pay, Non Certified Cert. N.A. $200 to max. $230. Increases for both groups $10 per mo. after 1-yr. on staff. 9-statutory holidays. All staff:— 5-day 40-hr. wk. Apply: Superintendent, Englehart & District Hospital, Inc., Englehart, Ontario.

Registered Nurses for 60-bed hospital. Salary $280 per mo. gross. Good personnel policies. For further particulars apply: Superintendent, St. Marys Memorial Hospital, St. Marys, Ontario.

Registered or Graduate Nurses for modern 100-bed hospital, 40-hr. wk., rotating shifts, good location near Rideau Canal Summer Resort, 1-hr. from Ottawa, for further details apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario.

Registered Nurses, Certified Nursing Assistants for modern 75-bed hospital. Starting salary: R.N.'s $300 per mo. with merit increases after 6-mo. service, C.N.A.'s $216 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, District General Hospital, Dryden, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospitals of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $305-$352, 28-day vacation after 1-yr. C.N.A. salary $221-$252, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board $45.00 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty for 50-bed hospital, good salary & personnel policies. Apply: Director of Nursing, Memorial Hospital, Huntsville, Ontario.

Registered Nurses for General Duty (2) urgently needed for 48-bed hospital. Highest salary paid. Telephone 378 or reply to: The Administrator of St. Joseph's General Hospital. Little Current, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $285 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $285, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $285 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; $285 gross. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for 350-bed General Hospital located in downtown Toronto — Rotating hours of duty, attractive personnel policies, in-service education program. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

Public Health Nurse (qualified) for a completely generalized program. Salary range, pension plan and other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurses (Qualified). Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurse (qualified) salary $3,650 - $4,400, allowance for experience. 5-day wk., 4-wks. vacation, sick leave credits, P.S.I., pension plan. Apply to: Mr. A. F. Stewart, Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurses (qualified) for generalized program in a highly urbanized & rural area. Personnel policies & further information on request. Apply to: Dr. A. F. Bull, Medical Officer of Health, Halton County Health Unit, Milton, Ontario.

Public Health Nurses (2-qualified) for generalized program, annual increments $200, 5-day wk., car allowance 10 cents per mile, group insurance plan, 4-wk. vacation. Apply stating salary expected to: Dr. W. N. Turpel, M.O.H. & Director, Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurses (Qualified) for generalized program in rural & semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario.

Public Health Nurses (Qualified). Salary $3,500 - $4,575, annual increment $215. 5-day wk., transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

Public Health Nurses (2-qualified) for generalized program with City of Peterborough. Personnel policies available on request. Apply to: R. D. P. Eaton, M.B., D.P.H. Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurses (qualified) for generalized program including some bedside nursing. Salary $3,500 with 10 annual increments of $200. Employer shared pension plan, group insurance & P.S.I. Location 25-mi. from Toronto. Apply to: The Director, Ontario County Health Unit, Pickering, Ontario.

HAMILTON GENERAL HOSPITALS

Opportunities for

PROFESSIONAL NURSES

Positions available in all Clinical Areas

(1) Obstetrical Unit

Apply to:
SUPERINTENDENT OF NURSING,
MOUNT HAMILTON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

(2) Medical Unit

Apply to:
SUPERINTENDENT OF NURSING,
NORA-FRANCES HENDERSON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

(3) Medical - Surgical - Pediatric Unit & Operating Room

Apply to:
DIRECTOR OF NURSING,
HAMILTON GENERAL HOSPITAL,
BARTON STREET EAST,
HAMILTON, ONTARIO.

Personnel Policies sent on request.

DIRECTOR OF NURSING

REQUIRED FOR

163-bed hospital for a term of nine to twelve months, while present director is on a leave of absence to further her postgraduate studies.

for further particulars please write to:

ADMINISTRATOR,
KIRKLAND AND DISTRICT HOSPITAL,
KIRKLAND LAKE, ONTARIO.

ONTARIO SOCIETY

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CRIPPLED CHILDREN

Requires Immediately

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

- GOOD SALARY RANGE
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You will deal directly with children, their parents and service club members.

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FOR CRIPPLED CHILDREN
92 COLLEGE ST., TORONTO 2

Public Health Nurse, (qualified) for generalized program. Salary range $3,500 - $4,325 according to qualifications & experience. Car expense allowance & other benefits. Apply to: Dr. G. L. Anderson, Director, The Lambton Health Unit, Sarnia, Ontario.

Public Health Nurse (qualified) for Supervisory responsibilities, to serve as Assistant Supervisor. Salary range $4,400 - $4,940 according to qualifications & experience. Car expense allowance & other benefits. Apply to: Dr. G. L. Anderson, Director, The Lambton Health Unit, Sarnia, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, Hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½ days monthly, vacation 4-wk. per yr., car car allowance, salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J. R. Mayers, M.O.H. and Director, Norfolk County Health Unit, Box 247, Simcoe, Ontario.

Public Health Nurses (Qualified) for Victorian Order of Nurses (Toronto Branch). Minimum salary $3,800, consideration given to past experience. Annual increments, 5-day wk., 4-wk. vacation. $100 uniform allowance. P.S.I.'& Supplementary Blue Cross available, pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto 2, Ontario. WA. 1-3184.

Public Health Nurse (Qualified-Catholic) for St. Elizabeth Visiting Nurses' Association. Minimum salary $3,825, annual increment, 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto 2, Ontario. EM 8-1863.

Public Health Nurses (qualified) for generalized program in the Township of North York (pop. over 250,000) adjacent to Toronto. Salary range $3,840 - $4,413, starting salary based on experience, excellent employee benefits. Apply to: Dr. Carl E. Hill, M.O.H., 5000 Yonge Street, Willowdale, Ontario.

Public Health Nurses for generalized program, salary range $3,700 - $4,500 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan & other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario.

Public Health Nurse for generalized public health nursing service in Oxford County. Salary range $3,400 — $4,275 with annual increments of $175, 5-day-wk., 1-mo. vacation. Good personnel policies including car allowance, pension plan, cumulative sick leave. Loan available for purchase of car. Apply to: Supervisor of Public Health Nursing, Oxford Health Unit, Woodstock, Ontario.

P.E.I.

Director Public Health Nursing. Provincial (100,000 Population) qualified & experienced in supervision & administration. Apply giving reference etc. to: Director, Public Health Nursing, Box 3000, Charlottetown, P.E.I.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Nursing Office Supervisor, Medical Arts Instructor, Nursing Arts Instructor for 300-bed Toronto Hospital with expansion program, invites applications from experienced staff. Excellent conditions, rates of pay, & employee benefits. Apply in confidence. — Box O, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50-mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk., 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 60-bed General Hospital, salary $275 per mo. 5 semi-annual increases; 40-hr. wk., 4-wk. vacation. Cert. N.A. starting salary $200, 3-wk. vacation. Accommodation available in new motel-style nurses residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Fellow Nurses — if you know of any doctor in Southern Ontario who requires a Graduate Nurse for a responsible position in his office, with experience, please write: Box P, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

SASKATCHEWAN

Head Nurse, Operating Room in modern 100-bed hospital, basic salary $314, with recognition for P.G. courses, university training & for previous experience, 40-hr. work wk., good personnel policies, residence available. Apply to: Director of Nurses, Union Hospital, Weyburn,, Saskatchewan.

Registered Nurses (2) for 22-bed hospital. Salary $290 with increments to $367 per mo., 2-yr. exp. start at $319 per mo., board $34.50, personnel policies in accordance with Registered Nurses' Association. Residence on grounds with T.V. Apply: Secretary, Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty for 14-bed hospital. Salaries per SRNA schedule plus experience, 40-hr. wk., full maintenance in residence at $34.50. Apply to: J. V. Nouch, Sec.-Mgr., Union Hospital, Elrose, Saskatchewan.

Registered Nurses for General Duty in Operating Room, Emergency & Ward service in 180-bed hospital. Working conditions as recommended by the Saskatchewan Registered Nurses' Association. Apply to: Miss G. I. Bradshaw, Director of Nursing, Victoria Union Hospital, Prince Albert, Saskatchewan.

Operating Room Nurse for 26-bed hospital in Northern Saskatchewan; starting salary $325, also **Registered Nurse** starting salary $300. 2½% semi-annual increments. Consideration given for qualifications & previous experience. Complete maintenance at $30, 1-mo. annual vacation, fare paid from Prince Albert or Edmonton. Apply: Matron, Municipal Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $350 with range to $390 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses — Openings for General Staff Duty in all services including orthopedics, pediatrics, obstetrics, intensive therapy, rehabilitation, surgery. Challenging opportunities for personal & professional advancement. Apply: Personnel Director, Mount Zion Hospital & Medical Center, 1600 Divisadero Street, San Francisco 15, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurse (immediate position on staff) for new 150-bed hospital. Immediate California registration available. Write: Director of Nursing, Little Company of Mary Hospital, Torrance. California.

Staff Nurses for 144-bed General Hospital (30 min. from Los Angeles cultural & educational center). **General Duty:** $345 per mo. min.-days. ($22.50 dif. for 3-11 & $10 dif. for 11-7). Benefits: Time and ½ over 8-hrs. or 48-hr. wk. Soc. Sec., 2-wk. vacation end of 1-yr. 6 paid holidays, 1 day month sick leave (cumulative to 30-days). **Graduates** of accredited schools — California license obtainable immediately. Apply: Mildred Croddy, R.N., Director of Nursing, Martin Luther Hospital, 1825 W. Romneya, Anaheim, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro, area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21. California

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Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital. Oakland 11, California.

NATIONAL OFFICE

CANADIAN NURSES' ASSOCIATION

requires

Registered Nurse with advanced preparation in Administration for position of Associate Executive Director. Experience must include administration. Helpful to have had business administration. Master's degree preferred.

For further information please contact

MISS PEARL STIVER, EXECUTIVE DIRECTOR,
CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA 2, ONTARIO.

DIRECTOR OF NURSING

Required for 111-bed, fully accredited Sanatorium, specializing in the active treatment of and research in Tuberculosis and other Chest Diseases. Situated 55 miles north of Montreal, in the heart of the Laurentian Mountains.

Modern and comfortable suite accommodation, 40-hour week, 1 month vacation with pay, excellent personnel policy, with conventional benefits.

Salary open to discussion, pending experience and qualifications.

Please apply to:

THE EXECUTIVE DIRECTOR,
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NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $285-$315 monthly ($131.20 - $145 bi-weekly) $265 monthly ($122 bi-weekly) until registered. Rotating periods of duty — 40 hour week, 8 statutory holidays, annual vacation 21 days. Annual sick time 12 days, cumulative to 18 days. Hospitals of Ontario pension plan, Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $350 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered Nurses for expanding 424-bed General Hospital near Chicago's West Side Medical Center. Starting salary $390; $420 for P.M.'s & nights. Benefits include 8 paid holidays, up to 4-wk. vacation, sick leave, Blue Cross & pension plan. Convenient to "Loop" & super highways. Private room accommodations available. Write: Diretor of Nursing Service, Dept. C.J.N., Mount Sinai Hospital Medical Center, 2750 W. 15th. Place, Chicago 8, Illinois.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $380 for days, $410 for evenings, $400 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $405 days, $435 evenings, $425 nights, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

SCHOOL NURSE for small infirmary in girls' private school, 20-mi. from N.Y.C., pleasant opportunity. Apply: P.O. Box 308-Summit, New Jersey.

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Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

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THE PARENTERALS PAGE NUMBER 2

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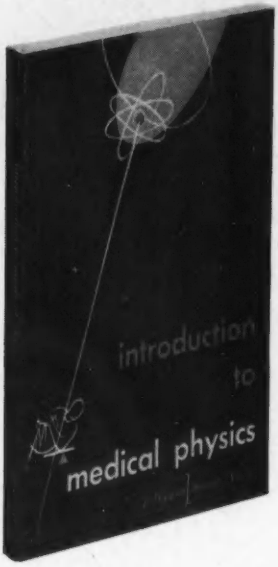

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